Counsellors' perceptions of their role in working with people who are HIV positive or have aids

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COUNSELLORS' PERCEPTIONS OF THEIR ROLE IN WORKING WITH PEOPLE WHO ARE HIV POSITIVE OR HAVE AIDS

by

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TO MY BELOVED JESUS

Jesus said, "Take away the stone." Martha, the sister of him who was dead, said to Him, "Lord, by this time there is a stench, for he has been dead for four days." Jesus said to her, "Did I not say to you that if you would believe you would see the glory of God?" (John 11:39-40)

ABSTRACT

A critical review of the literature shows little evidence of the benefits of counselling for people infected with the HIV virus and rigorous follow-up studies are generally lacking. Authors reviewed in the literature urge the need for training in counselling. However, whether counselling training is a necessity in the context of HIV/AIDS is debatable as no evidence has yet suggested that trained counsellors are more effective than untrained ones. Therefore, it is necessary to know how counsellors perceive their role in relation to people with HIV/AIDS. It is also essential to know what skills and training they regard as necessary for working with this group of clients.

This thesis reports the results of two separate studies. Twelve questionnaires were returned and 3 interviews were conducted in the preliminary study among a small sample of people responsible for counselling women with HIV/AIDS. The results demonstrated that most counselling for this group of clients was not carried out by trained counsellors. It was concluded that counselling was not a central response to those clients. Acknowledgement of the limitations of this preliminary study led to the main study which was conducted among experienced and student counsellors on the perceptions of their role in working with people with HIV/AIDS.

A number of significant differences were found between the perceptions of 30 experienced counsellors and 46 students in the questionnaire survey of the main study. However, experienced counsellors did not appear to feel better prepared than students in working with people with HIV/AIDS. Inconsistent results were found which suggested no agreement about whether counselling for people with HIV/AIDS required different skills and training to counselling other groups of clients. Furthermore, inconsistency between responses to different questions suggested that although respondents acknowledged a role in reducing the spread of HIV infection, they had not adequately thought through the implications of this for their counselling practice. The implications for counsellor training and supervision were discussed.

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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ARC	AIDS Related Complex
AZT	Zidovudine
BA	degree of Bachelor of Arts
BAC	British Association for Counselling
CDC	Centers for Disease Control, Atlanta, USA
CRUSE	Bereavement counselling
ddC	dideoxycytidine
ddI	dideoxyinosine
DHSS	Department of Health and Social Security
GP	General Practitioner
GUM	Genito-Urinary Medicine
HIV	Human Immunodeficiency Virus
HIV CT	HIV Counselling and Testing
IDU	Injecting Drugs User
IEC	Information, Education and Communication
IVDU	Intravenous Drug User
MA	degree of Master of Arts
NASA	National Advisory Service on AIDS
PhD	degree of Doctor of Philosophy
Relate	Marriage counselling
STD	Sexually Transmitted Disease
WHO	World Health Organisation

DECLARATION

This thesis results entirely from my own work and has not been previously offered for any other degree or diploma.

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Part One: Introduction

Chapter one: Introduction and scope of study

The reasons for my choice of this research topic were originally from my interests in conducting research concerning the complexity of human sexuality. I had some prior experience of carrying out a research project on human sexuality which concentrated on the comparison of gender identity of "transsexuals" with "heterosexuals", "homosexuals", and "bisexuals" in 1990. Through this project, I became aware of various problems transsexuals were facing because of fear of rejection and prejudice in society, which often led them into social and personal isolation. The majority of them were withdrawn into living a "double life" with their transsexual identity being hidden from their families and friends, and society. Counselling for this group of clients was most problematic, and counsellors' values and attitudes towards the beliefs and behaviours of transsexuals were greatly challenged.

I have discovered some similarities between counselling for transsexuals and for people with HIV/AIDS[1] which challenge the practice of counselling in general. Counsellors are facing clients who:

[1] HIV stands for Human Immunodeficiency Virus; and AIDS stands for Aquired Immune Deficiency Syndrome. It is important to distinguish between HIV and AIDS. The needs of people who are HIV infected are not the same as people who have been diagnosed as having AIDS. However, for the purpose of this study, HIV/AIDS will frequently be used as an inclusive term to include all aspects of the disease.

- fear rejection, stigma and prejudice from their families, friends and society;
- refuse to reveal their transsexual identity or HIV status; and
- require the assurance of anonymity; it is not common for a client to remain anonymous in counselling.

I became aware that many counsellors feel ill-prepared and ill-equipped for their task and the quality of counselling being offered to these clients was unknown.

Initially, the focus of this thesis concentrated on the provision of counselling for people with HIV/AIDS who were predominately homosexuals. However, I have become aware of the changing pattern in the proportion of people with HIV/AIDS from homosexuals to heterosexuals, especially women and children.

Thus, this thesis reports two separate studies. The first phase of field work is a preliminary study carried out among a small sample of people responsible for counselling for women with HIV/AIDS in 1996. The second study is the main study of the thesis, conducted among experienced counsellors and student counsellors in 1998.

The rationale for conducting research among workers who provide counselling for women with HIV/AIDS is dependent upon the dramatic increase in numbers of women with HIV/AIDS having been reported. This obviously supports the argument that women are becoming more vulnerable to HIV infection. Counselling intervention is then recognised most urgently in responding to the crisis women with HIV/AIDS are inevitably facing. Thus, study of the provision of counselling for women with HIV infection becomes necessary in order to discover whether counselling is a central response to this group of clients.

The results of the preliminary study demonstrated that most counselling for women with HIV/AIDS was not carried out by trained counsellors in those organisations I contacted for the research. However, counselling consistently appears as a desirable intervention in AIDS literature due to the absence of a vaccine and an effective cure for the disease. Given the fact that HIV counsellors are often not qualified or trained in counselling, a confusion arises about the nature of counselling required by people with HIV/AIDS and among care workers who provide such counselling. This leads to questions about whether counselling training is a necessity in the context of HIV/AIDS, and whether counselling for people with HIV/AIDS requires different skills and training to counselling other groups of clients. It was therefore decided to concentrate the main study on counsellors' perceptions of their role in working with people with HIV/AIDS.

Three key issues are focused on in order to explain the rationale for research into the preliminary study and the main study: first, the increasing number of women infected by HIV; second, psychological distress arising from awareness of HIV infection and AIDS; third, three main responses which help the vulnerable cope with the threat of HIV infection and AIDS - medical care, health education, and counselling. Finally, the scope and structure of the thesis will be summarised.

1.1. The increasing number of women infected by HIV

Homosexual men were the first to be diagnosed as having AIDS in the early 1980s (Koch, 1987; Echenberg, 1988). Many of the people infected with HIV also used drugs and were affected by various infectious agents. As a result, social research emphasised the sexual practices and the use of drugs by homosexual men and intravenous drug users (IVDUs) at the beginning of the AIDS epidemic. However, the numbers of AIDS cases confirm a steady spread of the disease among heterosexuals (Holland *et al*, 1990ab; Brown, 1991; Peckham & Newell, 1990; Bury, 1992; Sobo, 1995). Worldwide, 90% of new infections in 1992 shifted to heterosexual men and women (ACET Annual Report, 1992/93).

Compared with men, women were considered as having a lower risk of infection (Holland *et al*, 1990ab). It was not until 1986 that attention was focused on the increasing numbers of women with HIV/AIDS. The World Health Organisation estimated that more than 3 million women worldwide were already infected with HIV; and 40% of individuals who would develop AIDS during 1990 and 1991 would be women (Yogev & Connor, 1992). In Sao Paulo (Brazil), HIV prevalence in male patients at venereal-disease clinics remained stable between 1993 and 1994, yet it jumped by 500% among women (Purvis, 1996). In 1995, the number of cases in males fell by 9% (from 1532 to 1349), and the number of cases in females rose by 4% (from 220 to 228) in the UK (Communicable Disease Report, 1995a).

Table 1.1 shows the global AIDS epidemic on the current numbers of people still living with HIV/AIDS, the percentage who are women and the latest figures of deaths in 1996.

Table 1.1: The global AIDS epidemic - the numbers of people living with HIV/AIDS, the percentage who are women and the latest figures of deaths in 1996

Countries	People living with HIV/AIDS	% who are women	Deaths in 1996
North America	750,000	20%	61,300
Latin America	1,300,000	20%	70,900
Caribbean	270,000	over 40%	14,500
Sub-Saharan Africa	14,000,000	over 50%	783,700
North Africa and Middle East	200,000	20%	10,800
Western Europe	510,000	20%	21,000
Central and Eastern Europe and Central Asia	50,000	20%	1,000
South and Southeast Asia	5,200,000	over 30%	143,700
East Asia and Pacific	100,000	20%	1,200
Australia and New Zealand	13,000	20%	1,000

Source: Adopted from Purvis, 1996:46-47 (UNAIDS: all numbers are estimates as of December, 1996).

Two significant factors attempt to explain the dramatic increase in the numbers of women with HIV/AIDS:

- the possibility that women have been under-diagnosed, and
- the possibility that women and children are more vulnerable to HIV infection.

1.1.1. The possibility that women have been under-diagnosed

It is possible that women were under-diagnosed at the beginning of the AIDS epidemic. The diagnosis of AIDS depends on the appearance of one of the conditions defined by the Centres for Disease Control (CDC) in the United States (Bury, 1992). Bury argues that although this list of conditions was broadened in 1987, it still did not include any of the gynaecological conditions that are associated with HIV infection in women. Consequently, women might die from HIV-associated conditions without a diagnosis of AIDS (Bury, 1992). Reviewing a study of deaths of women with HIV/AIDS, Bury (1992) found that 48% died of conditions that were not listed in the CDC definition for AIDS.

Moreover, Sobo (1995) points out that after the amended official definitions of AIDS by the CDC in 1993, opportunistic infections likely to strike women (such as invasive cervical cancer) were included. Since then, the number of women diagnosed with AIDS has increased dramatically. Two hundred and four percent (204%) more women were diagnosed with AIDS in the first three months of 1993 than in the same time period in 1992 (Sobo, 1995).

1.1.2. The possibility that women and children are more vulnerable to HIV infection

There are four possibilities which suggest that women and children are more vulnerable to HIV infection:

a) women lack knowledge about and access to reliable contraception,

b) women are more likely to be infected through heterosexual transmission,

c) women are possibly infected by HIV at an earlier age,

d) women survive a significantly shorter time after a diagnosis of AIDS, and

e) the increase of women with HIV and the impact on paediatric AIDS.

a) Women lack knowledge about and access to reliable contraception

Holland *et al* (1990) suggest that since young women in the UK lack knowledge about and access to reliable contraception, and also lack power in the sexual encounter, they are a particularly vulnerable group to HIV infections. Many respondents both in interviews and on questionnaires expressed dissatisfaction that sex education was "too little, too late" in Holland *et al*'s study.

b) Women are more likely to be infected through heterosexual transmission

Roughly 60% of the women in Boland's study (1992) became infected as a result of heterosexual contact with infected males. Bury (1992) and Sobo (1995) both suggest that women are more likely to be infected by heterosexual transmission than men for two reasons.

The first reason is that an infected man is slightly more likely to infect a woman during sexual intercourse than the other way around. Sobo (1995) argues that women are more vulnerable than men to the transmission of heterosexual HIV infection, because women involved in heterosexual intercourse are generally on the receiving end. She believes that as reception involves at least minimal tissue trauma, receiving women are at a biologically higher risk for infection than their penetrating partners (Sobo, 1995). Sobo (1995) finds that this is especially true when force is used during sex or when sex is tempestuous, when damage to vaginal or anal tissue is more likely. She suggests that teen-aged girls are particularly vulnerable biologically because their vaginal linings are not as thick as those of mature women.

Secondly, at present, more heterosexual men are infected with HIV than women (Bury, 1992; Purvis, 1996). These infected men include a large pool of bisexual men, injecting drug users and haemophiliacs (Amaro, 1993; Sobo, 1995). Therefore, women are far more likely to encounter an infected man than vice versa. In Edinburgh, it was estimated that 1 in 100 men aged 15 to 45 years were infected with HIV compared to 1 in 250 women (Bury, 1992). This suggests that women in Edinburgh were more than twice as likely to meet an infected man than a man was to meet an infected woman.

c) Women are possibly infected by HIV at an earlier age

According to the Communicable Disease Report in the UK (1995b), there was a marked difference in the age distribution of AIDS diagnosis between men and women thought to have acquired their infection through heterosexual exposure. This evidence showed that the modal age group is 35 to 44 years for men (29%, 208 of 714) and 25 to 29 years for women (34%, 188 of 547). This difference suggests that these women might have been infected at an earlier age than these men. Sobo (1995 and Lacayo, 1996) especially emphasised that teen-aged girls often had sex with older men who had had more opportunity for acquiring HIV infection. Moreover, Boland gave an example of a survey of US Job Corps applicants aged 16 to 21 from 1987 to 1990. Among applicants aged 16 and 17, the rate of HIV infection was much higher among females than among males.

d) Survival of women with AIDS

Bury (1992), Haynes *et al* (1996) and Thompson (1996) raised the issue that people had been living longer after a diagnosis of AIDS over the last few years. However, studies of survival of people with AIDS showed that women survived a significantly shorter time after a diagnosis of AIDS than men in the UK and the United States (Bury, 1992). Bury reviewed a study comparing the progression of HIV infection in both male and female drug users of similar background where all had been receiving good medical care in Edinburgh in 1991. The result showed that male drug users were found to survive longer after a diagnosis of AIDS than female drug users.

Therefore, the increase in the number of women with HIV/AIDS suggests that the demands on medical, practical, and personal emotional support systems for women are increasing rapidly. Many youth in Michaels & Levine's study were likely to have been born before their mothers

were infected with HIV, and as a result were not at risk of prenatal infection. When those women with AIDS die, they leave children of different ages, some of whom need shelter, food, and medical care, and all of whom need emotional support and guidance (Michaels & Levine, 1992).

Obviously, the increase in the number of infected men had a direct impact on the number of their female sexual partners. It has been reported that:
a) increasing numbers of women worldwide are living with AIDS (Michaels & Levine, 1992; Yogev & Connor, 1992; Communicable Disease Report, 1995a); and
b) the fastest growing category of people with AIDS are women of childbearing age - 15-44 years old (Boland, 1992; Yogev & Connor, 1992; Sanford & Vosmek, 1993).
Consequently, the increase in the number of infected women had a direct impact on the number of paediatric AIDS cases.

e) The increase in women with HIV and the impact on paediatric AIDS

The AIDS epidemic poses painful moral dilemmas for both HIV-positive women and their health-care providers regarding the reproduction decision (Arras, 1990), when decisions need to be made on the continuation or preparation for pregnancy, or abortion.

The first paediatric AIDS patient was diagnosed two years after the first adult case was reported (Canosa, 1991). Various reports specify that 2.5%-3% of all AIDS cases worldwide occur among children. Yet, due to the peculiar characteristics of HIV infection in children and the difficulties in reporting, it is possible that the proportion is higher, probably of the order of 7%-8% (Canosa, 1991). By the year 2,000, ten million infants and children worldwide will be infected with HIV and most of them will die before their fifth birthday (Yogev & Connor, 1992).

The impact of the AIDS epidemic upon children is already noticeable in the United States. In inner-city Baltimore, about 1 in 80 children are born to an HIV-infected mother (Hutton & Wissow, 1991). By early 1992, 3,500 cases of paediatric AIDS had been reported, and about 1,800 additional children with HIV infection are being born each year (Boland, 1992). As HIV has a long incubation period, the number of paediatric HIV infections could be higher than it was estimated. Many believed that 10,000 to 20,000 children were infected nationwide in the USA (Boland, 1992). In 1992, approximately 10% of all paediatric hospital beds in the USA were occupied by children with AIDS (Yogev & Connor, 1992).

At the Johns Hopkins Hospital, about half of the pregnant women found to be seropositive after voluntary testing reported no risk factor for HIV infection (Hutton & Wissow, 1991). Hutton & Wissow (1991) reported that there were many women without known or acknowledged risk factors who were infected and were bearing infected children. For many of these women their child's illness was the first indication of their own infection and health risk (Hutton & Wissow, 1991; Yogev & Connor, 1992; Sobo, 1995). In some cases, an infant with HIV appears to increase the chance of being abandoned or rejected after birth by the mother with HIV/AIDS (Hutton & Wissow, 1991).

The understanding of vertical transmission from mothers to infants

Since paediatric infection is closely linked to maternal infection, it is not surprising that its prevalence parallels that of AIDS in women (Peckham & Newell, 1990). Therefore, the increase in the number of women with HIV infection has a great impact on the incidence of vertical transmission among children. According to Hutton & Wissow (1991), vertical transmission from mother to child became the predominant source of HIV infection among pre-teenage children. Thus, prevention of paediatric AIDS is dependent on prevention of infection in the mother (WHO, 1987).

However, very little attention was given to the understanding of vertical transmission as one of the main HIV transmission routes. Although 90% of the respondents in Galt *et al*'s (1989) study[2] knew that vertical transmission was one of the main routes of transmission, no respondents in Kaul *et al*'s (1991) study[3] had this knowledge. Three factors were found in Brown-Peterside *et al*'s (1991) study on General Practitioners[4]:

a) more than 60% of medical trainees lacked knowledge about HIV/AIDS in babies;
b) 45% trainers vs. 51% trainees lacked knowledge about the transmission of HIV in breast milk; and
c) only 32% trainers vs. 35% trainees answered correctly on the importance of positive HIV testing in new-born babies.

[2] Galt et al (1989) studied 766 respondents who were 18- & 19-year-old in Doncaster.
[3] Kaul et al (1991) studied 792 university students who were between 18 to 20 years old in West Glamorgan.
[4] Brown-Peterside et al (1991) studied 616 trainers and 538 trainees in seven health regions in England and Scotland.

Orphans whose mothers die of AIDS

As younger women become HIV-infected and develop AIDS (Michaels & Levine, 1992; Communicable Disease Report, 1995b; Sobo, 1995; Lacayo, 1996), the proportion of children who are orphaned may be expected to increase (Canosa, 1991; Hutton & Wissow, 1991; Boland, 1992; Michaels & Levine, 1992; Yogev & Connor, 1992; Chevallier, 1994).

Unless the course of the epidemic changes dramatically by the year 2,000, the overall number of motherless children and adolescents will exceed 80,000 in the United States (Michaels & Levine, 1992). [5] According to Michaels & Levine (1992), almost unnoticed, the HIV/AIDS epidemic has been responsible for the creation of a new, large, and especially vulnerable group of motherless youth - children, adolescents, and young adults - whose mothers have died of HIV/AIDS-related complications. Chevallier (1994) reports WHO's estimation that by the year 2,000 more than 5 million children under 10 years old (the majority of them will be in Africa) will have lost their mothers to AIDS.

Three significant reasons attempt to explain the definition that focuses on "motherless youth" instead of "fatherless youth" (Michaels & Levine, 1992).

- For the vast majority of youth, whose caregiving parent dies of an AIDS-related disease, the mother is that parent.
- Although there are families in which an uninfected father is willing and able to serve as the primary caregiver when the mother dies of AIDS, these situations appear to be rare.
- Since there are few data on the offspring of men dying of AIDS, this definition conforms to the realities of epidemiological analysis.

The death of a parent or other emotionally significant adult is one of the most traumatic experiences any child can suffer. When that death is accompanied by stigma (van den Boom, 1995) and isolation and is followed by instability and insecurity as it is in AIDS, the potential for trouble, both immediately and in the future, is magnified (Michaels & Levine, 1992). Some bereaved children and adolescents are already in foster care or are immediately taken in by relatives willing and able to care for them. They face the trauma of separation from family members, and unrecognised and unaddressed grief (Michaels & Levine, 1992).

[5] This refers to children who are under 13 years of age and adolescents who are between 13 to 17 years of age.

Uncertainty about the baby's HIV status

According to Mok (1993), it is impossible to tell whether a new-born baby is infected when the mother is already infected with HIV. There are three reasons for this. First, the presence of passively acquired maternal HIV antibodies has traditionally limited the usefulness of antibody testing for the infant born to an HIV infected mother. Second, antibody loss occurs between five to eighteen months. Third, 50% of these infants will become antibody negative at ten months old. However, those infants who are infected are usually persistently antibody positive beyond 18 months of age. Nevertheless, 18 months is a long time to wait for a diagnosis. Fortunately, research (Mok, 1993) has shown that a diagnosis can be reached as early as two or three months, using a combination of clinical and newer laboratory tests.

As discussed above, HIV status may not be established in young babies for a long period, and can be up to two years in some cases (Walker, 1991; Mok, 1993). This means that the infant will require constant testing and the family will have to live with a period of uncertainty and apprehension. In my informal conversation with a paediatrician in September 1993, all the babies born to mothers with HIV were treated as HIV positive as soon as they were born in her hospital. Yet, many of them ended up being HIV negative later. This caused parents stress and the parents might blame the doctor for misdiagnosing. Psychologically, this period of waiting may also represent a severe crisis for a family already facing maternal and sometimes paternal infection. The mothers as carers face stress on recurrent illness in the child, coping with anticipating loss, loneliness, loss of control and normality, and they have to interact with a large number of health care providers.

Consequently, the impact of childbirth upon women with HIV/AIDS is tremendous and complex especially when the child's illness is the first indication of her infection. Although the breastmilk of a healthy mother is known to be the best infant food, the breastmilk of an HIV-infected mother could pose a risk of HIV transmission to an uninfected infant (Peckham & Newell, 1990; Canosa, 1991; Finger, 1992; Martino et al, 1992). Therefore, advice giving on the issue of infant feeding is one of the difficult issues that health workers have to face. There are other unanswered questions, such as the implications of paediatric AIDS, the clinical manifestations and the evolution of the infection, the care required by the child, coping with recurrent illness in the child, and the way in which death would come.

Both the mother and her partner will require continued support and counselling about lifestyle, safer sexual practices and the risk of a further pregnancy. They will also need education about the

infection and its implication for themselves as well as their children (Peckham & Newell, 1990). There is a need for continued training of counsellors to provide psycho-social support for those women and their families in the community (Peckham & Newell, 1990).

It is impossible to review all aspects of problems women with HIV/AIDS are facing (for instance, on the issue of sexual abuse during childhood and HIV infection).[6] Reidy *et al* (1991) recognise that caregivers of HIV children including mothers are in danger of becoming burned-out, physically and emotionally, by the stress brought on by this infection. Yet, it is important to bear in mind individual differences among women; to a greater or lesser extent some problems may appear more threatening than others. It was discussed before that diagnosis of HIV infection or AIDS, or a suspicion of recognition of the possibility of infection, brings with it profound emotional, social, behavioural, and medical consequences (WHO, 1990). Therefore, adjustment to HIV infection involves constant stress management and adaptation. The question is whether this can be best achieved by the intervention of counselling. As the implications of a positive test are considerable, antenatal testing for pregnant women without good counselling is not recommended (WHO, 1987).

1.2. Psychological distress arising from awareness of HIV infection and AIDS

The HIV and AIDS epidemic, which emerged in the last quarter of the twentieth century, has within less than two decades affected all corners of the world and spread to over 190 countries in all continents (Koch, 1987; Mertens & Low-Beer, 1996). By the end of 1995, and following an extensive country-by-country review of HIV/AIDS data, a cumulative total of 6 million AIDS cases were estimated to have occurred in adults and children worldwide; and currently 20.1 million adults are estimated to be alive and infected with HIV or have AIDS (Mertens & Low-Beer, 1996). Thus, AIDS is an international disease regardless of race, sexuality, or geographical factors.

[6] One of the largest studies of this kind was by Klein & Chao (1995). A large sample of 2,794 women who were the sexual partners of injection drug users were studied between 1990 and 1993.

1.2.1. HIV positive status and associated complex emotional conflicts

Once infected, the breakdown of the body's immune system leads to inevitable death (Smith, 1986; King, 1989; Arras, 1990; Dixon, 1990; Reidy *et al*, 1991; Kiemle, 1994). Between the beginning of 1982 and the end of 1996, the number of AIDS cases reported in the UK, who were known to be dead, or who were lost to follow-up and presumed dead, was 8,879, 71% of the 12,565 reported AIDS cases (Public Health Laboratory Service, 1996). This may produce psychological trauma, arising from the loss of a much longer life expectancy, to be faced by HIV positive individuals. Thus, the diagnosis of HIV infection is overwhelmingly terrifying. That is, the discovery of HIV results in insecurity and uncertainty which at times causes fear, panic, confusion and worry (Balmer, 1992).

Most people who suffer from AIDS may have been infected with the virus for a long time (often several years) before showing signs of its development (Sattaur, 1985; Ferry, 1987; Scott, 1987; Green, 1989; Dixon, 1990; Haynes *et al*, 1996; Thompson, 1996). Moreover, not everyone who is infected with HIV reacts in the same way (Scott, 1987). While some HIV-positive individuals succumb to AIDS within a few years, others may remain healthy for a decade or more (Thompson, 1996). Therefore, American experts on AIDS are recommending that AIDS should be classified as chronic rather than fatal (Roberts, 1996).

Haynes *et al* (1996) report the varied progression of AIDS among people with HIV infection under four categories (p. 324). First, approximately 10% of HIV-infected subjects progress to AIDS within the first 2 to 3 years of HIV infection. Second, approximately 5 to 10% of HIV infected subjects are clinically asymptomatic after 7 to 10 years. Third, the remaining 80-85% of HIV-infected subjects are projected to develop AIDS within a median time of approximately 10 years from initial infection. Fourth, 20 years after infection, 10 to 17% of HIV infected individuals will be AIDS free. Furthermore, Thompson (1996) reports that some people mysteriously manage to avoid HIV infection, despite repeated exposure to the virus.[7]

Therefore, the discovery of HIV positive status is likely to create great anxiety and insecurity.

a) There is a fear of not knowing when or how the infection occurred, how many other people were infected, how many of them will die or have already died (feeling of betrayal, guilt, shock).

[7] Thompson (1996) reports a study by William Paxton, of the Aaron Diamond AIDS Research Centre in New York, USA, and his colleages that a group of 25 people had frequently had unprotected sex with HIV positive partners, yet remained uninfected.

b) There is a fear of not knowing whether the infection will lead to symptoms, and in the long term to full-blown AIDS, and whether treatment can prolong life (uncertainty about medical aspects).
c) There is a fear for the future in not knowing when or how death will occur, how to prepare for death, how to survive, and what happens after death (death education, counselling for death).
d) There is a double burden as an infected person and a carer for another infected individual (a partner or a child).
e) There is a fear of not knowing how to cope with the knowledge that parents, who are dying, may not live to see their children growing up to adulthood (the significance of parenthood, the need for placing children for adoption).

The conflicts described above are sufficient to indicate an urgent need for counselling when people are receiving the outcome of HIV positive antibody testing. Does this suggest that psychological support should be a priority?

1.2.2. The epidemic of AIDS and psychological pressures

> "The AIDS epidemic exposes hidden vulnerabilities in the human condition that are both biological and social". (Fineberg, 1988:106)

a) Biological vulnerability

The AIDS epidemic exposes hidden vulnerabilities in the human condition that are biological, such as chronic health problems. Counsellors reported that the concerns of clients with AIDS are increasingly shifting towards losses associated with chronic health problems (Bond, 1991). Chronic illness does not only damage an individual's physical health, but also presents a series of psychological pressures at several levels as listed below (Anderson & Bury, 1988):

- separation from families, friends and other sources of gratification;
- loss of key roles;
- disruption of plans for the future;
- loss of self image and self-esteem;
- uncertain and unpredictable future;
- distressing emotions such as anxiety, depression, resentment and helplessness; and
- permanent changes in physical appearance or in bodily functioning.

b) Social vulnerability

Despite the biological vulnerabilities, the AIDS epidemic also exposes hidden social vulnerabilities in the human condition, such as stigma and discrimination. Stigmatisation of people suffering physical or mental illness has commonly occurred throughout history. Individuals with infectious diseases, such as leprosy, plague, tuberculosis and syphilis, or mental illnesses such as schizophrenia, have been subjected to discrimination such as confiscation of property, quarantine or loss of human rights (King, 1989; Kiemle, 1994). Such discrimination has always existed and is often associated with fear of contamination and death. Thus, separation or exclusion of people with such conditions becomes the consequence (King, 1989; Kiemle, 1994).

The above description also applies to people with HIV infection and AIDS. It is generally accepted in the medical field that HIV is the cause of AIDS. It is also believed that HIV typically leads to a diagnosis of AIDS. Therefore, stigma attached to people with AIDS also includes people who are HIV positive. There is a common assumption that AIDS is 'caused' by homosexuality, intravenous drug abuse, prostitution and certain ethnic origins. The term 'risk group' becomes a metaphor for otherness and a community divided into us and them (King, 1989). Several studies (Aggleton *et al*, 1988; Galt *et al*, 1989; Gray & Saracino, 1989; Hastings *et al*, 1987a; Skinner *et al*, 1991) indicate that AIDS has not been an issue of personal concern in general. This suggests that stigma is attached to people with HIV/AIDS not only on the basis of physical disease but also a diagnostic label, and this may create a considerable burden for them even in the absence of illness. Therefore, it is not surprising to discover that people with HIV/AIDS often face rejection and hostility from family and society as a consequence.

c) Personal vulnerability

Apart from the above hidden vulnerabilities that are both biological and social, Mann *et al* (1992) also raise three issues of personal vulnerability to HIV/AIDS. Personal vulnerability to HIV infection increases:

- with a lack of accurate, relevant, and comprehensible information about HIV;
- when the individual is not concerned or sufficiently motivated regarding the danger of HIV infection; and
- when the individual lacks skills to gain access to needed services, supplies, or equipment; and lacks the power or confidence to sustain or implement behaviour changes.

It is clear that people with HIV/AIDS are frequently exposed to the vulnerabilities discussed. They need emotional acceptance and psychological support when experiencing such problems. Therefore, awareness of HIV infection and AIDS can create enormous psychological pressures and anxieties that can delay constructive change or worsen illness (WHO, 1990).

d) Suicide and HIV/AIDS

Physical illnesses, particularly those that are life threatening, are associated with increased suicide risk (Pugh *et al*, 1993; Rabkin *et al*, 1993; Pugh, 1995). Although there is no definite estimate on the number of suicidal deaths for people with AIDS, HIV/AIDS is associated with an increased likelihood of suicide, and suicidal ideas are relatively common in people with HIV/AIDS (Boland & Harris, 1992; Campbell, 1995; Catalan & Pugh, 1995; Miller, 1995; Sherr, 1995bd; Starace, 1995). This is especially the case when patients experience neurological symptoms that include epilepsy and confusional states. These symptoms are very common among individuals with HIV infection, occurring in over 50% of patients (Pugh, 1995). Moreover, HIV has been linked to a wide range of neuropsychiatric syndromes including depression, anxiety, psychoses, and delirium. All of these are independent suicide-risk factors in their own right. Several studies (Boland *et al*, 1992; Pugh *et al*, 1993; Marzuk & Perry, 1993; Rabkin *et al*, 1993; Sherr, 1995b) suggest that no single variable or even a set of variables is a compelling predictor of suicide.

Rabkin *et al* (1993) found that hopelessness, a strong risk factor for subsequent suicide, increased as physical health deteriorated, and low perceived social support correlated with increased hopelessness.

Physical illness can also lead to psychiatric morbidity, especially depression. Up to 45% of patients attending a central London AIDS clinic are receiving psychiatric treatment, the main diagnosis being depression (Pugh, 1995). Over 30% are likely to have had psychiatric intervention in the past, and 23% have made previous suicide attempts and 17% of these have been repeated (Pugh, 1995). A psychiatric history was present in four of the six cases in Pugh *et al*'s (1993) study.

It is important to bear in mind that more basic social, economic and environmental factors (such as social stress, economic crisis, community disruption) are the direct cause of some diseases and

important determinants of the health-damaging behaviour that leads to other illness (French & Adams, 1986; Tones *et al*, 1990), including AIDS.

1.3. Three main responses to help the vulnerable cope with the threat of HIV infection and AIDS

As AIDS is an incurable disease, through medical care, health education, and counselling, the key responses to the global AIDS epidemic is to help the vulnerable:

a) avoid the infection by preventive means - health education, counselling;
b) cope with the initial infection in socio-emotional terms - help clients to cope with stigma, discrimination, isolation through health education and counselling;
c) live and maintain a healthy life, physically, socially, and emotionally after being infected and before the manifestation of the disease - health education and counselling for people who are HIV positive but well;
d) provide medical treatment for symptoms, and improve quality of life after the disease itself is established - health education and counselling for people with AIDS, and medical treatment;
e) prepare for death when becoming terminally ill - death education, counselling people with terminal illness.

1.3.1. Medical care

The AIDS pandemic has developed primarily through two stages, namely, the aetiology of the disease (Anderson & May, 1987; Gallo, 1987; Koch, 1987; Sattaur, 1985; Scott, 1987) and its pathogenesis (Gollo, 1987; Kingman, 1987; Macklin, 1989; Berridge, 1992). These two stages are usually considered in a disease-centred approach based upon the scientific paradigm, to describe, direct and control the medical response (Balmer, 1992). The focus on the disease-centred approach of HIV/AIDS has the weakness that little consideration is given to the array of emotional, social and environmental factors affecting health.

Once people know their HIV positive status, they are faced with decisions about how to proceed for treatment, forcing them into an unfamiliar world of medical uncertainty (Walker, 1991 and Mann, 1991). Zidovudine (AZT) was initially formulated as an anticancer drug, and is an established treatment for HIV-infected individuals with symptoms (Gallo, 1987; Mann, 1991;

Delta Coordinating Committee, 1996). Although this is the main drug used for AIDS, it can make people feel very ill and can have debilitating side effects causing a need for blood transfusion (Aggleton, 1989; Dixon, 1990). It is not a cure, but does prolong life. It is very expensive and only available to those who live in wealthy western countries (Dixon, 1991; Lacayo, 1996; Purvis, 1996).

Because the benefits of AZT in HIV-infected individuals were small and did not last long, the Delta[8] trial was designed to test whether combinations of AZT with ddI[9], or ddC[10] were more effective than AZT alone in extending survival and delaying disease progression (Boulton, 1996; the Delta Coordinating Committee, 1996). The results confirmed that treating patients infected with HIV with a combination of AZT plus either ddI or ddC, prolonged life and delayed disease progression compared with treatment with AZT alone.[11]

However, there was debate on the effectiveness of the treatments and related political issues. Three arguments are important for consideration, according to Lacayo (1996). First, as mentioned before, drugs for treating AIDS are very expensive. Combination therapy, according to Lacayo (1996), costs $11,280 annually. Second, Lacayo (1996) reported estimates of patients, who showed no improvement or could not tolerate the side effects, varying from 15% to about 33%. He argued that for those people, the promising developments of the treatment could only threaten them and deepen their isolation. Third, the new drugs were being denied to most HIV-positive children. This suggests that the drug companies have neglected paediatric AIDS because children under 12 are a small market in all senses (Lacayo, 1996).

As discussed above, there is optimism and varying degrees of success in the medical treatment for prolonging life and delaying disease progression for people with AIDS. However, there is a need for urgent attention to the fact that the majority of people with HIV/AIDS who kill themselves or who make suicidal attempts have been: (a) in recent contact with doctors, usually General

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[8] Delta is conducted by a European/Australian group co-ordinated by Britain's Medical Research Council and the Agence National de Recherches sur le SIDA in France (Pinching, 1996). 3,207 HIV-infected individuals internationally were followed up for an average of 30 months in the Delta study (Delta Coordinating Committee, 1996).

[9] ddI: dideoxyinosine, an adenosine analogue (Delta Coordinating Committee, 1996)

[10] ddC: dideoxycytidine, a cytosine analogue (Delta Coordinating Committee, 1996)

[11] The results show that (Boulton, 1996; the Delta Coordinating Committee, 1996):

- in patients who received a combination of AZT and ddI, there was a relative reduction in mortality of 42% compared with those who received AZT alone;
- a 32% reduction in mortality was found in patients receiving AZT plus ddC;
- in those who had received AZT before, the addition of ddI improved survival by 23%, but there was no direct evidence of benefit from the addition on ddC.

Practitioners but also psychiatrists (Pugh *et al*, 1993); and (b) receiving good medical care with trust in their doctors (Rabkin *et al*, 1993). This indicates a deficiency in that good medical care and psychiatric treatment are not sufficient to improve the quality of the client's life. What can counselling offer here that psychiatric treatment and medical care can not? Are there any overlapping characteristics between medical care, psychiatric treatment and counselling? How do they succeed in improving the client's quality of life? What are the differences between psychiatric treatment and counselling?

It is clear that AIDS is not only a biological condition, but also a psychological and social condition. A greater concern, in helping people with HIV/AIDS coping with crisis and working through feelings and inner conflicts, is raised here. Such concern needs to be addressed within the context of confidential counselling.

1.3.2. Health education

Wiseman (1989) suggests that it is widely accepted that efforts to deal with the threat to public health posed by HIV infection will depend on their success in health education and not on some 'magic bullet' in the form of a drug. Aggleton *et al* (1993) support the view of Wiseman that in the absence of a vaccine against HIV or a cure for AIDS, the only way in which we can halt the epidemic is through effective health education.

However, the majority of public education campaigns about HIV/AIDS have so far tended to assume that people are capable of making personal choices about safer sex and drug use (Richardson, 1990). Richardson (1990) argues that this reflects the dominant ideology underlying health education practice in general that health is normally regarded as something over which the individual has personal control. It is true that HIV is not as contagious as are other well-known viruses and does not seem to be transmissible through casual social contact. Why is it that a variety of health conditions, which are to a large extent preventable, continue to be transmitted at a worrying rate (Balmer, 1992; Boland, 1992; AIDS Care Education and Training, 1992/3; Sherr, 1995a; Sobo, 1995; Mertens & Low-Beer, 1996; Purvis, 1996)? Why has the rate of HIV infections through sexual transmission among heterosexuals not slowed to almost a standstill, in response to the vast sums of money being spent on public education campaigns (Wilton & Aggleton, 1991)? There are a number of severe problems which prevent the effectiveness of education about HIV infection and AIDS in changing behaviours:

- AIDS and HIV involve two major sensitive and taboo areas of our social function, namely 'sex' and 'death' (Skinner *et al*, 1991; Kiemle, 1994; Ratigan, 1997).
- There is a tendency to project the risk of HIV infection on to others, thereby denying personal risk (Hastings *et al*, 1987a; Aggleton *et al*, 1988; Galt *et al*, 1989; Gray & Saracino, 1989; King, 1989; Skinner *et al*, 1991). Overcoming this denial of personal risk is made more difficult by the long latent period between infection and the initial signs of the illness appearing.
- A complex relationship exists between knowledge, attitudes and behaviour, particularly when the negative effects of the behaviour are only likely to be felt many years into the future (Skinner *et al*, 1991).

Several studies indicate that most models of health education are based on information-giving (Ewles & Simnett, 1990; Health Education Authority, 1988; Homons & Aggleton, 1988). It is difficult to generate outcome measures for HIV/AIDS health education, which include the reduction of new HIV cases, the improvement of knowledge, the adoption of safe and appropriate preventative measures, and appropriate reactions to those infected (Sherr, 1989). In relation to AIDS education, it is suggested that most of these interventions have taken place within the context of pre-test and post-test counselling (Green, 1989; Burnard, 1992a; Porche *et al*, 1992). Therefore, this approach to AIDS health education gives significance to the potential role of counselling in responding to the threat of AIDS. However, some authors suggest that HIV/AIDS counselling modifies behaviour in only 10-20% of at-risk individuals (Pape *et al*, 1992). Some counselling sessions may turn out to be little more than impersonal information-giving exercises, rather than counselling in a more growth oriented or therapeutic sense. Health education is not synonymous with counselling and clear distinctions need to be made between the two approaches despite their areas of overlap (Sherr, 1989).

1.3.3. The increased demand for counselling

The continued and projected increase in the number of people infected with HIV has a direct impact on all helping professionals, including counsellors (Hunt, 1996). It is evident, according to the AIDS literature, that one of the key elements of care for people with HIV/AIDS is counselling. It was discussed in sections 1.3.1. and 1.3.2. that counselling is a means of intervention for the sake of people's psychological well-being when medical and health education interventions are very limited. However, can counselling be a supplement?

Four important issues were outlined from callers to the National Advisory Service on AIDS (NASA) telephone help line (Slavin & Smith, 1987).[12]

1) Many callers did not simply require information, but wished to talk through issues concerning their sexuality and sexual practices. The helpline was used as a vehicle for raising concerns about sex.
2) There was a need for explicit information in order to pass the message across, such as simple and detailed descriptions of risk, modes of transmission and safer sex practices.
3) AIDS information needed to be presented in different ways for different audiences.
4) Serious consideration needs to be given to the effects of AIDS on sexual relationships and practices.

An observable advantage of telephone helplines is that enquirers were given a guarantee that there was no possibility that their identity would be exposed. Three factors revealing callers' desire for counselling were most obvious in this survey (Slavin & Smith, 1987). First, while many people gained their knowledge of AIDS mostly from television (Kaul & Stephens, 1991; White *et al*, 1988), however good a television programme was, some people were bound to want to check their own personal circumstances on a one-to-one basis. Second, many callers did not simply request information about HIV/AIDS, but a desire to talk to someone about their fear and worries was displayed. Many callers were pleased and relieved to be able to talk through their own fears and worries with an advisor. Third, a number of them were very distressed and the desire to talk to someone at length was urgent. All three factors suggested that the demand for counselling in response to the epidemic of AIDS was increasing and essential. This emphasises the need for one-to-one intervention which can be best achieved by individual counselling.

House *et al* (1995) suggest that counsellors trained in the 1990s will be working directly or indirectly with AIDS-related issues, regardless of their work settings. They strongly urge immediate inclusion of counselling training about HIV/AIDS for all counsellors. Furthermore, Hunt (1996) argues that counsellors have an ethical obligation to be trained to adequately provide the needed service to people who are affected by HIV/AIDS, and those who set up training programmes have an ethical obligation to provide this training.

[12] The National Advisory Service on AIDS (NASA) was funded by the DHSS for the health departments in the UK to provide free and confidential advice for listeners to the BBC national radio AIDS campaign on radios 1, 2, & 4 in December 1986. The service was expanded and re-opened in January 1987 to offer the same free and confidential advice and support the DHSS leaflet "AIDS-Don't Die of Ignorance" and the BBC's local radio campaign.

1.4. Scope of the thesis

In order to investigate whether counselling is the central response to women with HIV/AIDS and the perceptions of experienced and student counsellors in working with people with HIV/AIDS, Part Two (chapters two to four) reviews literature within the larger contexts of theory and practice of counselling, and effectiveness of HIV/AIDS counselling. Chapter two carefully examines the nature of counselling relating to the major approaches to counselling and therapy. This chapter also includes aims, concepts and therapeutic relationships that are central to counselling in relation to the theories of psychology. Areas of agreement and difference in definitions of counselling and HIV/AIDS counselling are closely considered in Chapter three. The discussion also focuses on whether the WHO's definition of HIV counselling accommodates the practice and theory of counselling; and whether HIV/AIDS counselling is a different kind of counselling (from counselling people with no HIV/AIDS). Chapter four examines the effectiveness of HIV counselling and testing, and whether there is any parallel with counselling in medical settings.

The empirical research is based on two separate phases of field work conducted in 1996 and 1998. Part Three (chapters five to seven) explores the rationale and procedures for conducting the preliminary study among workers who provide counselling to women with HIV/AIDS. Chapter five discusses methodology and the advantages and disadvantages of a questionnaire survey and interviews. The results are reported in Chapter six and discussed in Chapter seven. The results of the preliminary study lead to the recognition of the need for the main study. Part Four (chapters eight to ten) describes the second study in this research which was carried out among experienced counsellors and student counsellors. Chapter eight discusses methodology chosen for this study. The results are interpreted in chapter nine in which suitable statistics are selected and explained. Chapter ten relates the results of both studies to the literature review and draws general discussions and conclusions.

Part Two:

Literature Review

In order to investigate whether counselling is the central response to women with HIV/AIDS and the perceptions of experienced and student counsellors in working with people with HIV/AIDS, Part two (chapters two to four) reviews literature within the larger contexts of theory, practice and effectiveness of HIV/AIDS counselling.

CHAPTER TWO: THE NATURE OF COUNSELLING

Introduction

The previous chapter focused on key issues to explain the rationale for research into the practice of HIV counsellors for women with HIV/AIDS, and the perceptions of counsellors regarding their role when working with people with HIV/AIDS. It is evident that there is an increasing demand for counselling in meeting the challenge of HIV/AIDS. However, there is confusion about the nature of counselling required by people with HIV/AIDS and among care workers who provide such counselling. Therefore, this chapter carefully examines the nature of counselling and concentrates on the issues below:

1. three main theoretical approaches to counselling and therapy with an analysis of similarities and contradictions;
2. definitions of the therapeutic relationship;
3. the aims of counselling; and
4. the eclectic or integrative approach to counselling.

2.1. Three main approaches to counselling and therapy

Counselling practice has its roots in a number of traditions, philosophies and schools of psychology.[13] Historically, three main schools of psychology, which are psychoanalytic, behavioural, and humanistic, formulate the principle theories and practices in counselling and therapy (Nelson-Jones, 1982; Burnard, 1992a; McLeod, 1993; Hough, 1994; Woolfe & Dryden, 1996).

These three approaches represent fundamentally different ways of viewing human beings and their emotional and behavioural problems. These approaches include a broad variety of theories or models and are outlined as follows (Brammer *et al*, 1993; McLeod, 1993; Hough, 1994; Clarkson, 1996; Woolfe & Dryden, 1996).

- The psychoanalytic approach, which includes all psychodynamic models of counselling and therapy, has its origins in Freudian ideas, together with Jung's Analytical Psychology, Adler's Individual Psychology, and the Object Relations theorists.
- The behavioural approach to counselling and therapy links directly to the learning theories of Behavioural Psychology. However, there has been a progressive movement away from the more rigid ideas of pure behaviourism, towards a wider view of personality that encompasses cognition and human interaction. This has led to the evolution of cognitive therapies, one of the most enduring of which is rational-emotive therapy (Ellis).
- The humanistic approach to counselling and therapy includes Person-Centred Counselling (Rogers), Gestalt Therapy (Perls), Transactional Analysis (Berne), experiential psychotherapy, and Existential approaches to therapy (May).

This section explains the main theories and concepts central to counselling, their practical applications to counselling, and techniques and methods applicable to therapeutic interventions. However, it is important to bear in mind that this tripartite grouping of therapeutic approaches can be misleading (Hough, 1994; Woolfe, 1997). For instance, as mentioned before, rational-emotive therapy, along with other cognitive approaches, has somehow developed quite separately from the influences of behaviourism. Also, transactional analysis is sometimes referred to as a cognitive model (Hough, 1994). Humanistic and existential traditions contain rather different

[13] More detailed discussions on the roots, history, and cultural origins of counselling in McGowan & Schmidt (1962) Chapter 1: Introduction to Counselling; and Bond (1993) Chapter 2: What is counselling; and McLeod (1993) Chapter 1: What is counselling? The cultural origins of contemporary practice.

views of human nature and some people argue that they should be discussed separately (e.g. Palmer & McMahon, 1997).

2.1.1. Psychoanalytic approaches

Much of classic psychoanalytic theory is based on three major assumptions about human nature that are summarised as follows (Hansen *et al*, 1977; Patterson, 1980; Brammer *et al*, 1993; McLeod, 1993; Hough, 1994; Gladding, 1996).

a) The initial five years of an individual's development are most crucial. These early years are the prime foundation and determine the adult behaviour of the individual.

b) The sexual impulses of an individual act as key determinants of behaviour. Sexual impulses are generally interpreted as the need for each individual to gratify all bodily pleasures.

c) Much of an individual's behaviour is controlled by unconscious determinants.

a) Freudian theory

Freud's theory is most significant because a great number of prominent theorists of counselling (i.e. Adler, Ellis, Perls) were directly influenced by his concepts (Gladding, 1996). Freud's psychoanalytic approach developed partly as a result of his medical practice during the late 1880s. Freud structured the personality into three related elements, "the pleasure principle of the id, the reality principle of the ego, and the morality principle of super-ego" (Hough, 1994:2).

- The id is that area of the personality that is primitive and delineates the real unconscious. It is illogical and filled with instinctual energy that is continuously demanding recognition and release. Present from birth and necessary for survival, the id is primarily concerned with securing food, comfort and pleasure.
- The ego is more logical than the id since it has been modified through contact with the external world. The 'reality principle' of the ego, as opposed to the 'pleasure principle' of the id, becomes clear when the child has developed a realistic awareness of self, and of the world.
- The super-ego is beginning to develop by about three years of age. It is shaped gradually from that part of the ego that has absorbed parental, cultural, and familial influences. The 'morality principle' is the basis of the super-ego and its main function is to restrain the demands of the id. For this reason it is primarily concerned with conscience and moral judgements.

Freud believed that these three elements had to be balanced and in harmony in order to ensure psychological health. Other Freudian concepts, which were influential to counselling practice, are the unconscious mind, repression, and resistance.

Unconscious

The distinction which Freud made between the conscious and the unconscious mind was quite clear. The former represents a realm of the mind that is accessible, which includes all those thoughts and feelings of which individuals are aware. Yet, the latter describes a domain of the mind whose content and material is normally inaccessible except through the experience of dreams, fantasies, or slips of the tongue. Unconscious impulses, Freud believed, are active in governing a large number of everyday feelings and behaviour. The unconscious level is composed of those memories and ideas which the individual has forgotten. Freud believed that the unconscious built up the entire personality and had a powerful influence on behaviour. Therefore, unconscious problems are highlighted in the therapeutic relationship. It is important to make the unconscious conscious, according to Freudian theory, in order to effectively reduce neurotic problems. There is a further emphasis on the connection between unconscious thoughts and the way these influence relationships with other people and behaviour.

Repression and Resistance

Repression and resistance are twin concepts central to an understanding of the psychodynamic model. Repression is said to occur when an individual forces, from his or her consciousness, an impulse that causes anxiety. Then, the individual attempts to get rid of the impulse simply by refusing to acknowledge its existence (Hansen *et al*, 1977). For instance, memories that are painful, traumatic or shameful are often unacceptable to individuals, so they respond by repressing them from conscious awareness. It is this phenomenon of repression that Freud viewed as being of most importance in his formulation of psychoanalytic theory. Resistance is the phenomenon that is repressed in the unconscious. It is firmly located there by the ways in which individuals obstinately resist any attempts to uncover it.

As a result, psychodynamic counsellors believe that clients who are firmly committed to the idea of therapeutic change will, nevertheless, vigorously resist any intention to look closely at past experiences or events that are painful for them. The task of the counsellor is to encourage clients to acknowledge and, if possible, to talk freely about these past events and experiences. This task can only be accomplished if the counsellor: a) fully understands the grounds for the client's

resistance, b) is aware that it is a tendency in all clients, and c) is sensitive towards the client who is engaged in the difficult process of change.

During Freud's lifetime, several important figures in psychoanalysis were involved in disputes with him. The best known of these are Jung and Adler.

b) Jungian theory

Jung formulated his own theories which he termed Analytical Psychology after the breakaway from the original psychoanalytic school. Jung disagreed with Freud on a number of issues, including the subject of sexuality. In Jungian terms, this represents a small function of the mind and body, and is only one of a number of important drives. Others include spiritual and cultural drives that are especially significant in the second half of life, for Jung. Jung stressed the uniqueness of human motives and the striving toward individuation. In Freudian theory, childhood is the most important factor in shaping adult personality. Jung, on the other hand, puts less stress on the individual's past experiences but places more emphasis on the way humans have developed historically. In his view, ancestral history has shaped the human brain, so that influences from the past are constantly with humans. For Jung, Freud's concept of personal unconsciousness does not adequately explain all areas of human experience. The collective unconscious is a unique concept to Jung. The human psyche is regarded as very complex, and includes the important dimension of the collective unconscious that is present even before the individual has acquired any life experience.

c) Adlerian theory

Following his resignation from Freud's circle, Adler set up his own school of Individual Psychology. Adler agreed with Freud's concept of the unconscious. Yet, like Jung, Adler disagreed with Freud's insistence on sexuality as the major influence on personality development. Thus, for Adler, Freud's emphasis on biological and instinctual drives was restrictive. Adler emphasised the purposiveness of human beings. His view of human nature was optimistic, and emphasised the importance of social interest, as well as integration and interrelation with the wider community in which a person lived. Adler regarded the concept of the inferiority complex as one of the key discoveries of individual psychology. The term refers to the feelings of inferiority which people experience when they find themselves in situations that they would like to improve. The origins of inferiority stem from early childhood when a state of dependence is common. Adler is well known for his concept of the *ego ideal* or the person's model of the kind

of person he or she would like to be, a prelude to the now popular concept of *self-image* (Brammer *et al*, 1993).

Both Jung and Adler stressed the value of the direct and face-to-face contact of the psychotherapist with the client, as contrasted with the less direct, couch-centred treatment of the Freudians (Brammer *et al*, 1993).

d) Object relations theorists

Object relations theorists, such as Klein, focus on the importance of very early relationships in shaping personality. Object relations theory enables counsellors to look at clients' problems, which relate to intimacy, dependence, and identity, in a different light and from a different perspective to the Freudian viewpoint. This theory deals with the infant's relationship with its mother or primary care-giver, and pays special attention to the first weeks of life when a strong bond should be forming between infant and parents. The infant's relationship with parts of the mother's body and with non-human objects is of special interest. Object relations theory has helped to influence the way hospitals deal with children's problems because of separation from parents, and has focused attention on the need to encourage contact and bonding between infants and parents.

e) Applications to counselling

Freud's ideas have been continually modified and developed by others. As a result, many counsellors and therapists would see themselves as working within the broad tradition initiated by Freud, but would call themselves psychodynamic in orientation rather than psychoanalytic (McLeod, 1993).

Today, the psychodynamic counsellor, while obviously influenced by Freudian theory and its emphasis on past events, is equally interested in the client's ability to cope with everyday needs, events and problems. The Adlerian approach to therapy and counselling emphasises the client's subjective perception to reality. In this respect, it is often described as 'phenomenological'. Other approaches to counselling, including person-centred (i.e. Rogers and Maslow) and Gestalt, have extended this position.

An essential difference between psychodynamic and behavioural and person-centred approaches lies in the area of the understanding of development in childhood. The behavioural approach and the person-centred approach are silent on child development. There is a problem in the psychodynamic approach, where the emphasis has traditionally been placed on the importance of childhood events. Such emphasis may obscure or mask some of the client's current problems and difficulties (Brammer *et al*, 1993; Hough, 1994). These include financial and other material forms of deprivation, and such issues need to be addressed if the client is to make any real progress in dealing with emotional distress. It is also possible that many clients who come for counselling are simply not interested in an introspective approach to their problems, but prefer immediate and more direct means of tackling issues that cause them concern.

Professionals who practice classical psychoanalysis play the role of experts (Gladding, 1996). According to Adlerian therapy, the counsellor's role is, among other things, a teaching one, with the emphasis on re-educating clients whose life goals and assumptions may be dysfunctional and mistaken. In object relations therapy, the role of the therapist is to use the therapist-client relationship itself as the focus of change. Through a process of identifying and interpreting these projections within a secure emotional relationship, the therapist guides the client in the resolution of dysfunctional identity splits and into the formation of healthy emotional attachment (Brammer *et al*, 1993).

Conflict between the id and super-ego produces anxiety that the rational ego seeks to reduce through a variety of defence mechanisms. This process uses up a great deal of psychic energy. The methods used in psychoanalytic treatment include the following:

- Free association or the 'talking cure', which encourages clients to recall incidents and information from the past and from childhood. Although free association is still used in psychodynamic counselling, open discussion between client and counsellor is regarded as an important component of therapy and one which helps to equalise the balance of power between them.
- Interpretation, which is meant to lead to insight and to the assimilation of new information by the ego.
- For Freud, dream interpretation was the royal road to a knowledge of the unconscious activities of the mind (Hough, 1994). In psychodynamic counselling, clients are encouraged to become aware of their dreams in order to facilitate a deeper understanding of the unconscious forces that influence their lives.

- Both analysis of resistance and analysis of transference are meant to help clients gain access to unconscious conflicts and feelings.

One of the Adlerian therapist's devices to gain clues to his or her client's lifestyle is to ask for "first recollections" (Brammer *et al*, 1993). This approach gives the therapist an idea for the experiences on which the client's style of life is based.

Although the techniques of Freud's original model have been modified in contemporary psychodynamic therapy, there is still an emphasis on working through unconscious motives in order to uncover emotional problems and achieve insight.

2.1.2. Behavioural approaches

Behaviour therapy, or behaviour modification, has evolved from that branch of psychology that is concerned with theories of human learning. Classical conditioning and operant conditioning are two major theories of learning. Both theories are based on scientifically tested principles that have been formulated as a result of laboratory studies and experiments (Hansen *et al*, 1977; Hough, 1994). This is in sharp contrast to the Freudian and psychodynamic theories, which are unscientific in the sense that they have not been rigorously tested in order to establish their validity. Thus, there is no real experimental scientific evidence to support Freud's concept of personality (the id, the ego and the super-ego) and the existence of the unconscious.

a) Classical conditioning

Historically, behaviourists evolved from the Pavlovian conditioned-response approach to learning of the 1920s. His objective orientation resulted in a heavy emphasis on studying behaviour through the medium of animal experiments. Pavlov's classical conditioning makes use of the fact that some events in an individual's environment are related to some human neuro-muscular and glandular responses. Many such unconditioned stimulus-response connections are present at birth, and most of them are concerned with maintaining the existence of the organism.

b) Operant conditioning

The basic principles of operant conditioning have been outlined by Skinner. Skinner discovered that if a certain behaviour was followed by an event in the environment which brought

satisfaction to the individual, then the probability of that behaviour occurring in the future was increased. As a result of his research, Skinner designed a model for controlling behaviour based on principles of reinforcement. Skinner argued that the environment was the sole determiner of behaviour. He saw humans as completely reactive beings whose behaviour is controlled by external events (Hensen *et al*, 1977).

Thus, learning through operant conditioning is the opposite of learning through classical conditioning. The operant conditioning occurs because of what happens after a particular behaviour, while classical conditioning is concerned with the stimulus in the environment that causes the organism to respond.

One similarity between psychodynamic theories and learning theories is that they both emphasise the importance of conditioning in early life (Hough, 1994). However, learning theory does not claim that instinctive urges and repressed unconscious thoughts are the forces that regulate human behaviour. On the contrary, learning theory is concerned with actual observable behaviour. This approach stems from the work carried out by a number of psychologists, who experimented with animals in order to formulate and validate their theories at the beginning of the twentieth century. However, it was not until the 1950s and 1960s that a number of theorists began to translate learning theory concepts into counselling principles (Brammer *et al*, 1993; Hough, 1994). In the 1950s, Eysenck began to treat people suffered from phobias, and based his work on the findings of earlier research by Pavlov on classical conditioning.

Within behaviourism itself, there came to be a recognition that a stimulus-response model was insufficient even to account for the behaviour of laboratory animals (McLeod, 1993). Therefore, the behavioural approach has combined the notions of thinking and behaviour since the 1970s, so that attention is given to the cognitive aspect of human experience that was previously lacking. Therefore, the term 'cognitive behavioural therapy' is often used interchangeably with the original term, behaviour therapy, and has become much more developed in the past twenty years.

c) Applications to counselling

An important focus of psychodynamic counselling is to help the clients achieve insight, and to recognise, understand and deal with the thoughts and emotions that cause their problems. Yet, the behavioural approach to counselling emphasises a very different kind of therapy. Behavioural counselling suggests that psychology should be much more scientific, should rely less on

subjective experience and introspection, and should study people's actual behaviour instead of its supposed instinctual causes. Clients are encouraged to view their problems as learned behaviours that can be unlearned. Therefore, there is a definite educational direction in behavioural counselling, and clients are taught skills that enable them to manage their lives more effectively.

Behavioural counselling, which has traditionally been regarded as a directive approach, is in many respects concerned with client self-management and client self-directed behaviour. There is less emphasis on the client's subjective experience than in a person-centred approach (see details on section 2.1.3).

The health and well-being of the client are of paramount importance in the therapeutic endeavour, and behavioural counsellors are concerned to facilitate clients' growth, development, self-control and ability to cope effectively within their environment. The current trend in behavioural counselling seeks to give more control to clients in order to increase their freedom of choice as well as their ability to make effective choices. Past experience is regarded as relevant, only in so far as it influences present behaviour. For this reason, behavioural counsellors are not concerned to dwell on the past or childhood events. Instead, they are more interested in looking at current difficulties, especially those which are of great concern to the client.

The most significant aspect of behavioural counselling, and the one that separates it from other approaches, lies in its strict adherence to measurement, recording and specification of problems and goals. Behavioural principles and procedures, which have been scientifically tested, are openly stated and frequently revised. Each client is seen as a unique individual with individual needs; thus, techniques and procedures are adapted to meet those needs.

The educational dimension of behaviour therapy can be used effectively in the counselling context when clients express a desire to be taught certain skills, such as assertiveness training, relaxation techniques, role-play, modelling, behavioural rehearsal, or systematic desensitisation.

Assertiveness training is an example of a behavioural approach to counselling and therapy that clients increasingly value. Relaxation techniques can also be taught in a wide spectrum of counselling situations. Such teaching is an effective way of helping clients to manage their own problems (especially those related to anxiety and stress), and to become more self-reliant. Relaxation is also used in short-term and crisis counselling. Both role-play and modelling can also be used effectively within counselling, regardless of the theoretical orientation of the

counsellor. Modelling, as well as role-play, are used to help clients overcome certain blocks or impediments that would hamper their chances of moving forward and becoming self-sufficient. In this respect, behavioural procedures can be said to help clients grow towards self-actualisation, a concept that is central to the person-centred model of counselling (Hough, 1994). Moreover, behavioural rehearsal consists of practising a desired behaviour until it is performed the way a client wishes. Systematic desensitisation is designed to help clients overcome anxiety in particular situations.

Many cognitive behavioural approaches involve cognitive restructuring. These strategies often involve an initial phase when the client self-monitors his or her thoughts, feelings, and behaviours. In a manner similar to the rational-emotive therapy, clients then learn to substitute more realistic (less distorted) self-talk for cognitive distortions (Brammer *et al*, 1993).

Cognitive-behavioural approaches appeal to many counsellors and clients because they are straightforward and practical, and emphasise action. The wide array of techniques provide counsellors with a sense of competence and potency (McLeod, 1993).

d) Cognitive-behavioural therapy

The cognitive behavioural approach has evolved out of behavioural psychology and has three key features: a problem-solving, change-focused approach to working with clients, a respect for rigorous evidence to demonstrate changes in their behaviour (McLeod, 1993).

Unlike the psychodynamic and person-centred approaches to counselling, which place a great deal of emphasis on exploration and understanding, the cognitive-behavioural approach is less concerned with insight and more oriented towards client action to produce change.

Beck has identified a number of different kinds of cognitive distortion which can be addressed in the counselling situation (McLeod, 1993:54).

- Overgeneralisation, which involves drawing general or all-encompassing conclusions from very limited evidence.
- Dichotomous thinking refers to the tendency to see situations in terms of polar opposites.
- Personalisation occurs when a person has a tendency to imagine that events are always attributable to his or her actions, even when no logical connection need be made.

e) Rational-emotive counselling

Generally, a behavioural counsellor is active in counselling sessions. The client learns, unlearns, or relearns specific ways of behaving. The counsellor may function as a consultant, teacher, advisor, reinforcer, or facilitator. In rational-emotive therapy, counsellors are active and direct. They are instructors who teach and correct the client's cognitions (Gladding, 1996).

Ellis' rational emotive therapy, moves away from the pure behaviourism, and stresses an "ABC" model of understanding change (Brammer *et al*, 1993; McLeod, 1993):

- the "A" refers to an activating event, which may be some action or attitude of an individual, or an actual physical event;
- the "B" is the person's belief about the event; and
- the "C" is the emotional or behavioural consequence of the event, the feelings or conduct of the person experiencing the event.

The rational-emotive model emphasises the need to understand clients and their problems, and identifies a further need to communicate this understanding and acceptance to the client. A danger of using rational-emotive procedures too early in counselling, is that they are often too confrontational for vulnerable clients, and thus, do not address their affective needs in the way that some other approaches do. Counsellors can be tempted to push their own belief systems in the hope that clients will change quickly and alter their irrational thinking.

Rational-emotive techniques are tailored to accommodate individual client needs, and for this reason they are diverse and wide-ranging. Many clients benefit from keeping a diary, for example, so that they can record their thinking and behaviour over a period of time. Homework arrangements can encourage clients to practise new skills or to modify dysfunctional behaviour. Rational-emotive counselling appears eclectic since it uses a variety of procedures, some of which are borrowed from other theoretical models. These include assertiveness-training techniques, role-play and a wide range of behavioural techniques. The contract between client and counsellor, which is an integral part of both rational-emotive therapy and transactional analysis, can also be used in a variety of counselling situations, especially when specific goals have to be outlined. The techniques which rational-emotive therapists use are always logical, directive, persuasive and essentially re-educative.

2.1.3. Humanistic approaches

The common ingredient in all humanistic approaches is an emphasis on experiential processes and concentrates on the 'here-and-now' experiencing of the client (McLeod, 1993).

a) Rogers

Person-centred, or client-centred,[14] therapy was developed by the American psychologist Carl Rogers. Person-centred theory grew in popularity in Britain during the 1960s when its main influence was initially in the field of education. More recently, it has become widely accepted in many other areas, including social work, health care, psychotherapy, and counselling (Hough, 1994). The central theme was the importance of the individual as a competent architect of his own destiny. Although this competence was occasionally disturbed by the changes of life, Rogers believed that each person has sufficient innate resources to deal effectively with whatever traumas, conflicts or dilemmas they experience.

The person, in the person-centred approach, is viewed as acting to fulfil two primary needs: the need for self-actualisation; and the need to be loved and valued by others. Both these needs are, following Maslow, seen as being independent of biological survival needs.

Rogers' person-centred approach to counselling emphasises the important dimension of "self". The self-concept is the person's picture of the self and the self-evaluation of this picture. The concept of self is a learned attribute. It is a progressive concept starting from birth and differentiating through childhood and adolescence. Experiences perceived to be incongruent (inconsistent) with the self-concept will lead to feelings of being threatened, anxious, confused, and inadequate. Then, people attempt to use "defence mechanisms" to deny or distort their perceptions of these experiences in order to reduce the threat to the self-concept (Brammer *et al*, 1993). This concept of client defences is generally associated with the psychodynamic model of counselling, and is not usually discussed in the context of the person-centred approach. This does not mean that defences do not exist. It simply means that in person-centred counselling the emphasis is primarily on the client as a unique person. The ways in which that person chooses to relate to the counsellor are accepted, even when defences are part of the communication. The person-centred counsellor believes that defences should become less important to the client when he or she has sensed unconditional acceptance from the counsellor in the long term.

[14] Rogers was the first psychologist to use the word 'client' as opposed to the word 'patient'.

The concept of actualising tendency is crucial in the person-centred model of counselling, because it places a firm emphasis on the innate ability of people to improve and to regulate their lives, if external forces allow them to do so. Often a person's actualising tendency is inhibited or obscured because of hostile circumstances, such as, emotional deprivation or traumatic experiences in childhood. In Rogers' view, it is always possible to reactivate the actualising tendency, and this can be achieved in counselling when the three core conditions are present.

Hough (1994) suggests that the concepts of the organismic self, self-concept, and actualising tendency are, in some ways, analogous to Freud's theory of the structure of personality. The id and the organismic self are similar, since both are meant to represent that part of the individual's psyche that is often neglected, repressed or ignored. The self-concept and the super-ego are also similar. They both describe the internalised rules, moral values and structures, which are largely laid down by other people, including parents and educators. The actualising tendency appears to echo the functions of the ego. These are concerned to mediate between the id and the super-ego, and in so doing to provide balance, harmony and true insight.

b) Maslow

Maslow is another theorist whose contribution to the person-centred approach to counselling is very significant. Like Rogers, Maslow is usually referred to as a humanistic psychologist, since both their approaches emphasise the uniqueness of human beings, and both are concerned with subjective experience and human values. This is quite different from the behaviourists who place concerns on overt behaviours, and the psychoanalysts who emphasise unconscious motives and the strong irrational forces that are said to drive the individual.

Maslow's view of the human person was essentially positive and optimistic, and was concerned to direct attention to the 'healthy' tendencies that he believed to be present in everyone. These include the search for knowledge and understanding, as well as the search for satisfying relationships and the development of rich emotional experience. He did not subscribe to the view that psychology could be general in its application, but believed that it should mainly concentrate on the study of individuals and their unique experiences.

c) Applications to counselling

The emphasis in the person-centred model of counselling is placed on the relationship between the client and the counsellor. This model of counselling also focuses on the therapeutic changes that can take place for the client when there is an atmosphere of warmth, respect and acceptance.

Rogers believed that a truly therapeutic relationship between client and counsellor depends on the existence of three 'core' conditions - congruence, unconditional positive regard, and empathy - within the counsellor. Rogers claimed that these conditions were not just important or useful, but sufficient in themselves. The view that no other therapeutic ingredients were necessary, invited a confrontation with psychoanalysts, for example, who would regard interpretation as necessary, or behaviourists, who would see techniques for inducing behaviour change as central.

The counsellor's role is a holistic one in person-centred counselling. The counsellor sets up and promotes a climate in which the client is free and encouraged to explore all aspects of self.

Person-centred counsellors make limited use of psychological tests. They are usually done only at the request of the client (Gladding, 1996). In practice, humanistic therapy usually takes place either in one-to-one, hour-long sessions, or in groups led by a facilitator. Most humanistic practitioners rely on dialogue as a means of helping clients to explore the meaning of their troubles, although some will also employ enactments (such as Gestalt two-chair work), exercises (such as guided fantasy) or expressive media (clay, paint, voice, dance), or role-play to facilitate the therapeutic process (Woolfe & Dryden, 1996:135). Transactional Analysis is ideal for use by counsellors who find themselves in situations where a teaching approach is needed, and where clients need to develop better communication skills.

2.2. Therapeutic relationships

As discussed before, most approaches to counselling and therapy view the client/counsellor relationship as the most significant aspect of counselling (Hansen *et al*, 1977, McLeod, 1993, and Hough, 1994). Regardless of which model of counselling is being used, the working relationship between client and counsellor is suggested as being of fundamental importance to the success of the therapy in progress (Brammer *et al*, 1993; Hough, 1994). Counselling is suggested

as a relationship consisting of various dimensions (Hansen *et al*, 1977). This section examines some variables in the counselling relationship (Hansen *et al*, 1977; Brammer *et al*, 1993; Hough, 1994).

2.2.1. Psychoanalytic approaches

The development of the counsellor/client relationship is considered to be crucial in psychodynamic counselling. This is because, in many ways, the therapeutic relationship recreates for the client, some of his or her early relationships, especially those with his or her parents or significant others in the past.

Transference and Countertransference

Transference is a central issue in the psychodynamic model of counselling, and is used as a means of looking more closely at the client's early relationships, especially with parents. It is a fact for the psychodynamic approach that people tend to transfer to new relationships, such as a counselling relationship, many of the feelings and attitudes that they experienced in childhood. While the concept of transference is central to the psychodynamic approach, the counsellor is concerned to limit the intensity of the client's feelings in this regard. If clients develop transference feelings for counsellors, then it follows that, in a close working relationship, counsellors will inevitably experience feelings for their clients as well. Therefore, counsellors need to be in touch with a professional supervisor to whom they report on a regular basis in order to monitor the quality of their work.

The issue of transference is not regarded as particularly important by Jung, but when it does arise it is openly discussed between client and counsellor. The Jungian approach views the client/counsellor relationship as essentially co-operative; it is also warm, relaxed and informal. The relationship between the Adlerian counsellor and the client is based on collaborative efforts and co-operation.

2.2.2. Behavioural approaches

Transference is not deliberately evoked in the behavioural approach. The emphasis on a strictly scientific approach can sometimes give the impression that behavioural counselling is soulless or

non-caring, but this is certainly not the case. As in other forms of counselling, a good client-counsellor relationship is regarded as essential if progress is to take place. When a good therapeutic relationship has been established, clients are more likely to feel confident, to explain their problems coherently, and to co-operate fully with therapeutic goals and procedures. Although behavioural counsellors are often described as active and directive, their main concern is to treat the client as a unique person whose welfare and co-operation are of paramount importance.

a) Cognitive behaviour therapy

However, Scott & Dryden (1996) argue that within cognitive behaviour therapy, the therapeutic relationship has received much less attention than the technical aspects of counselling. Cognitive-behavioural therapists take very seriously the necessity of establishing a good working alliance with the client. This relationship is often characterised as educational rather than medical. That is, teacher-student as opposed to doctor-patient. There is no concern with 'countertransference' as in psychodynamic theory, or 'congruence' in person-centred theory.

b) Rational-emotive therapy

In common with other models of counselling, rational-emotive therapy regards the relationship between counsellor and client as being very important. According to rational-emotive therapy, the counsellor's ability to remain detached, though understanding, is preferable, for in this way he or she is less likely to become trapped in the client's irrational thinking.

Whereas person-centred counselling is non-directive in its approach to clients, a view implicit in rational-emotive theory is that people who are emotionally disturbed need to be, actively and authoritatively, taught to accept themselves and others. For this reason, rational-emotive counsellors are more direct in their approach.

2.2.3. Humanistic approaches

At its heart, person-centred counselling is a relationship therapy. People with emotional problems in living have been involved in relationships in which their experiencing was denied, defined or discounted by others. What is healing is to be in a relationship in which the self is fully accepted and valued (McLeod, 1993). Therefore, the most important aspect of person-centred counselling

is the relationship established between client and counsellor. There is less concern about the direction in which clients will move but more concern about providing a relationship where they can move freely and safely in exploring their own feelings. The relationship is considered the central means for promoting healing and growth (Brammer *et al*, 1993). This relationship is non-directive and geared to developing the maximum amount of personal strength and confidence in the client.

Congruence

Congruence refers to the counsellor's ability to be a real or genuine person in the counselling situation. They are fully congruent only when they are "fully and accurately" aware of what they are experiencing at this moment in the therapeutic relationship (Rogers, 1961:282). The counsellor is perceived as a person who has no need to act as an expert, or to feel superior. Rogers believes that healing occurs through the client's experiencing an intensely human interaction within the context of an emotionally real relationship with the counsellor (Brammer *et al*, 1993).

Unconditional positive regard

Unconditional positive regard refers to the attitude that "the counsellor experiences a warm caring for the client which is not possessive and demands no personal gratification" (Rogers, 1961:283). Rogers (1961) suggested that this acceptance should be given to the client without any conditions attached to it. In the person-centred model, the client is seen as a unique person who, regardless of his or her problems or difficulties, has a right to be accepted.

Empathy

Empathy is used to describe a particular characteristic which the counsellor should possess in relation to the client (Rogers, 1942). When counsellors are empathic it means that they are capable of understanding the client in the deepest sense. They can stand in the client's shoes and perceive things as the client perceives them. They can also transmit this deep understanding back to the client who will be encouraged and supported by it. This ability to enter into the true spirit or feeling of another person's world is sometimes referred to as being within the client's 'frame of reference'. The ability to enter into the client's frame of reference is a fundamental requirement for the client-centred model.

However, behavioural counselling and rational-emotive therapy place less emphasis on the need for empathy in counselling. According to rational-emotive therapies, staying detached from the client's frame of reference is regarded as essential, since this is seen as the only sure way of remaining uncontaminated by the client's irrational thinking. Similarly, understanding and rational thinking are highly valued in behavioural counselling. Thus empathy is underplayed and would be considered unnecessary.

Warmth

Rogers (1942) describes how the quality of warmth and responsiveness on the part of the counsellor could make rapport possible. This can make the client/counsellor relationship gradually develop into a deeper emotional relationship. From the counsellor's point of view, Rogers suggests that this is a definitely controlled relationship, an affectional bond with defined limits. It expresses itself in a genuine interest in the client from the counsellor and an acceptance of him or her as a person. The counsellor frankly recognises that he or she becomes to some extent emotionally involved in this relationship. The counsellor does not pretend to be superhuman and above the possibility of such involvement. He or she is sufficiently sensitive to the needs of the client, however, to control his or her own identification in order to serve best the person he or she is helping (Rogers, 1942:87).

The nature of the client/counsellor relationship is not usually highlighted in any of the literature that describes behaviour therapy. For this reason, there is a common and mistaken belief that this approach lacks warmth and is therefore not appropriate in a true counselling situation. However, according to Hough (1994), counsellors who are genuinely concerned to meet the many and diverse needs of clients usually use behavioural techniques when they feel that the client will benefit from such an approach. This suggests that sensitivity to client needs is at the very heart of good counselling practice, and so the charge that behavioural practice lacks warmth is certainly open to argument. Counsellor warmth towards the client is not regarded as a necessary component in the rational-emotive counsellor/client relationship. Too much warmth is regarded by Ellis (1962) as distracting and liable to damage the hard work that the client needs to do.

Free dialogue

Gestalt therapy describes the foundation of the therapeutic relationship as free dialogue between client and counsellor. It affirms the primary values of the encounter between two human beings, both of whom are risking themselves in the dialogue of the healing process (Clarkson, 1989). The

central focus is the moment-by-moment process of the relationship between the client and the counsellor, and not only the client is changed by the counsellor but the counsellor is also affected and changed by the client (Clarkson, 1989).

2.3. Aims of counselling

An exploration of the literature establishes that counselling is claimed to be effective in achieving certain aims and goals (Balmer, 1992). Underpinning the diversity of theoretical models discussed above are a variety of ideas about the aims of counselling and therapy. McLeod (1993) listed the different aims of counselling as follows.

> "*Insight.* The acquisition of an understanding of the origins and development of emotional difficulties, leading to an increased capacity to make rational control over feelings and actions (Freud: 'where id was, shall ego be').
> *Self-awareness.* Becoming more aware of thoughts and feelings that had been blocked off or denied, or developing a more accurate sense of how self is perceived by others.
> *Self-acceptance.* The development of a positive attitude towards self, marked by an ability to acknowledge areas of experience that had been the subject of self-criticism and rejection.
> *Self-actualisation or individuation.* Moving in the direction of fulfilling potential or achieving an integration of previously conflicting parts of self.
> *Enlightenment.* Assisting the client to arrive at a higher state of spiritual awakening.
> *Problem-solving.* Finding a solution to a specific problem that the client had not been able to resolve alone. Acquiring a general competence in problem-solving.
> *Psychological education.* Enabling the client to acquire ideas and techniques with which to understand and control behaviour.
> *Acquisition of social skills.* Learning and mastering social and interpersonal skills such as maintenance of eye contact, turn-taking in conversations, assertiveness or anger control.
> *Cognitive change.* The modification or replacement of irrational beliefs or maladaptive thought patterns associated with self-destructive behaviour.
> *Behaviour change.* The modification or replacement of maladaptive or self-destructive patterns of behaviour.
> *Systemic change.* Introducing change into the way in which social systems (e.g. families) operate.
> *Empowerment.* Working on skills, awareness and knowledge that will enable the client to confront social inequalities.
> *Restitution.* Helping the client to make amends for previous destructive behaviour."
>
> (McLeod, 1993:6)

It is important to bear in mind that it is unlikely that any one counsellor or counselling agency would attempt to achieve the objectives underlying all of the aims in this list. All counsellors or therapists are generally interested in and concerned for their clients, and desire to help them. Traditionally, psychodynamic counsellors have focused primarily on insight. Humanistic practitioners have aimed to promote self-acceptance and personal freedom. Cognitive-behavioural therapists have been mainly concerned with the management and control of behaviour.

2.4. The eclectic or integrative approach

The field of counselling and psychotherapy is currently involved in an important debate over the relative merits of theoretical purity as against eclecticism or integration (McLeod, 1993). It is crucial to bear in mind that no matter which approach a counsellor or therapist prefers, all counsellors or therapists can manifest a real concern for their clients.

Brammer *et al* (1993) suggest that counsellors become ineffective when they try to fit their clients into their theories rather than finding theories that are useful in helping their clients. This is because each client is a unique individual whose needs are quite different from those of any other client. Thus, any one theory is not sufficiently comprehensive or systematic to guide the counsellor through the multitudinous problems in everyday practice. Therefore, according to Hough (1994), it is impossible to prescribe a single approach that could be applied to all counselling situations.

Eclecticism, which is the practice of selecting methods, techniques and concepts from a variety of approaches, does take account of client individuality and the diversity of needs. The term integrative is sometimes used to describe the eclectic approach, and many practitioners prefer it since it suggests a coherence and harmony that is not generally associated with the word eclectic (Hough, 1994). McLeod (1993) also raises the fact that there are important differences between eclecticism and integrationism, and several different types of integrationism.

It is clear that throughout the discussion in this chapter all theorists are influenced by what has gone before. For instance, Freudian ideas can be seen as representing an integration of concepts from philosophy, medicine, biology and literature. The client-centred model encompasses ideas from psychoanalysis, existential, and phenomenological philosophy. The cognitive-behavioural and rational-emotive models are examples of an overt synthesis of two strands of psychological theory - behaviourism and cognitive psychology.

A series of studies has shown that more and more practitioners were describing themselves as 'eclectic' or 'integrationist' in approach, rather than being followers of any one single model (McLeod, 1993; Hough, 1994). However, is it ever possible to integrate techniques and procedures from different models of counselling?

It seems that a sizeable number of counsellors who are person-centred in their basic orientation, do select and use ideas from other models, when and if clients request or need them. According to Hough (1994), it is possible, and frequently desirable, to use elements of rational-emotive, behavioural, Gestalt or psychodynamic counselling within the framework of the person-centred approach. Is it true that a directive or teaching approach can be used consistently with person-centred counselling?

In opposition, a significant number of practitioners remained convinced that eclecticism or integrationism is associated with muddle and confusion, and that it is necessary to stick to one consistent approach (McLeod, 1993). Gladding (1996) raises the issue against eclecticism that counsellors often do more harm than good if they have little or no understanding about what is helping the client. McLeod (1993) reviews three types of confusion.

First, theoretical purists argue that there are conflicting philosophical assumptions underlying different approaches, and that any attempt to combine them is likely to lead to confusion or inauthenticity. For example, within psychoanalysis the actions of a person are regarded as ultimately determined by unconscious motives arising from repressed childhood experiences. In contrast, humanistic theories view people as capable of choice and free will. It could be argued that these are irreconcilably opposing ways of making sense of human nature, and can only breed contradiction if combined into one approach to counselling.

The second type of confusion can be created by taking ideas or techniques out of context. For example, systematic desensitisation is a therapeutic technique that has been developed within a behavioural perspective in which anxiety is understood in terms of a conditioned fear response to a stimulus. A humanistic counsellor, who understands anxiety in terms of threat to the self-concept, might invite the client to engage in a process that could superficially resemble systematic desensitisation, but the meaning of the procedure would be radically different.

The third confusion which can result from an eclectic approach reflects the difficulties involved in mastering concepts and methods from different theories. Therefore, it may undermine effective training, supervision and support. If a theoretical model provides a language through which to discuss and reflect on the complex reality of work with clients, it is surely helpful to work with trainers, supervisors and colleagues who share the same language.

Conclusions

This chapter has summarised three main approaches to counselling and therapy. The picture, at least on the surface, is one of both diversity and agreement. The various points of view differ considerably in their basic concepts and theories. Can they all be true or valid?

According to Murdock *et al* (1998), most counsellors can identify a primary theoretical influence even though they might label themselves as eclectic. They also suggest that interpretation of any findings associated with this label would be difficult due to the lack of clear definition of the orientation. Furthermore, counsellors' reasons for adopting a theoretical orientation are (Patterson, 1980; Norcross & Prochaska, 1983; Murdock *et al*, 1998): a) the model fits their personality and/or values; b) the model has good research support; c) the model is logical; d) the choice of this model is based on the orientation of their supervisor; e) the choice of this model is based on their clinical experience; and f) the choice of this model is based on the counselling training they have received.

Research in counsellor development has found that more advanced counsellors (as compared to counsellors at earlier developmental stages) show lower anxiety and greater understanding of theory (McNeill *et al*, 1985). Vasco & Dryden (1994) reported in their study that when selecting a theoretical orientation:

- humanistic and psychodynamic therapists stressed 'orientation of own therapist';
- systemic therapists emphasised 'family experiences', and
- behaviour and cognitive therapists emphasised 'research results'.

As discussed already in this chapter, the above findings were not surprising given the paramount importance of personal therapy in the training of humanistic and psychodynamic therapists; the importance of family approaches to systemic therapists; and the importance of the empirical tradition within behaviour and cognitive orientations.

However, as discussed in chapter one: 1) the diagnosis of HIV infection or AIDS, or a suspicion of recognition of the possibility of infection, brings with it profound emotional, social, behavioural and medical consequences; and 2) HIV counsellors are often not qualified nor trained in counselling. These lead to the question whether counselling training is a necessity in the context of HIV/AIDS. Is there any evidence that trained counsellors are more effective than untrained counsellors? Therefore, the next two chapters place significance on the definitions of counselling and HIV counselling, and the effectiveness of HIV counselling and testing.

CHAPTER THREE: THE NATURE OF HIV/AIDS COUNSELLING

Introduction

Chapter one focused on key issues to explain the rationale for conducting the preliminary study and the main study. It was explained that counselling may be a means of intervention for the sake of people's psychological well-being, since there is still no cure or vaccine for AIDS, and medical and health education interventions are very limited. There is confusion about the nature of counselling required by people with HIV/AIDS and among care workers who provide HIV/AIDS counselling. For this reason, it was necessary to provide a review of the nature of counselling in Chapter Two. This will be employed as a foundation for critical evaluation regarding the nature of HIV/AIDS counselling in this chapter.

It is evident that counselling constantly appears in AIDS literature as a desirable intervention (Slavin & Smith, 1987; WHO, 1987; Homans & Aggleton, 1988; Carballo & Miller, 1989; Green, 1989; Sherr, 1989; Bor & Miller, 1990; WHO, 1990; Bond, 1991; Rugg *et al*, 1991; Boland, 1992; Burnard, 1992ab; Pape *et al*, 1992; Porche *et al*, 1992; Yogev & Connor, 1992; Sherr, 1993; Sketchley, 1993; Kiemle, 1994; House *et al*, 1995; de Plessis *et al*, 1995; Sherr, 1995abc; DiScenza *et al*, 1996; Hunt, 1996; Paniagua *et al*, 1998). However, what do these authors mean by "counselling"? This chapter tackles the following factors.

1. Different social groups contributing different meanings to counselling
2. Definitions of counselling - agreements and differences
3. Definition of HIV counselling
4. Values in HIV counselling
5. Quality of HIV/AIDS counselling: a different kind of counselling?
6. Provision of HIV/AIDS counselling by different care workers

3.1. Different social groups contributing different meanings to counselling

There is a diversity in the general usage of counselling by different professionals (McGowan & Schmidt, 1962; Bond, 1991; Rugg *et al*, 1991; McLeod, 1993; Rowland, 1993; Woolfe *et al*, 1993; Corney, 1997).

- In counselling settings, there is formal counselling that is offered by counselling agencies or trained professional counsellors.
- Counselling may occur between friends or colleagues.
- In school settings, counselling may take place between teachers and pupils.
- Counselling is commonly understood as a prescriptive and directive process in medical settings and doctors often interpret counselling as either advice-giving or problem-solving.
- In the area of finance and business, increasing references can be found to such activities as debt counselling or even double-glazing counselling.
- The woman who sells make-up is a beauty counsellor.
- The person who advises on matching curtains and wallpaper is called a colour counsellor.
- The majority of people working in the 'human service' professions, including nursing, the clergy, the police, self-help groups, staff telephone lines, and many others, would consider counselling to be part of their work role.

It is clear that the above list expresses the common difficulty people struggle with when providing counselling. This discloses the limited understanding of what counselling really means, and what counsellors have to offer. No understanding of theory or method of counselling is revealed in the list above. It is not surprising that counselling has been used and misused in all areas of human life. As a result of diversity of opinion and practice, counselling is interpreted differently by different individuals. Therefore, there is no doubt that anyone can claim themselves as providing counselling. This underlines the reality that there is confusion about the nature of counselling required by people with HIV/AIDS and among care workers who provide HIV/AIDS counselling. Thus, the next section attempts to clear this confusion and examines the various definitions of counselling regarding their agreements and differences.

3.2. Definitions of counselling - agreements and differences

Counselling has its own history and development that is recorded in counselling literature (Hansen *et al*, 1977; Brammer & Shostrom, 1982; Nelson-Jones, 1982; Bond, 1993; Brammer *et al*, 1993; McLeod, 1993; Hough, 1994; Clarkson, 1996; Woolfe & Dryden, 1996). There is neither copyright nor patent on the use of the term "counselling" (Woolfe *et al*, 1993). Therefore, efforts to formulate precise comprehensive definitions of counselling have faced great difficulty. The existence of agreements and differences between various definitions of counselling are inevitable. These agreements and differences of counselling definitions need to be addressed in order to uncover a flow of consistency or inconsistency across the definitions. This will be useful to aid the next discussion on whether the WHO's definition of HIV counselling accommodates the practice and theory of counselling. I will emphasise areas of agreement and difference in the definitions in "**Bold**" letters throughout this section.

3.2.1. Areas of agreement

It is crucial to bear in mind that all counselling, by definition, aims to benefit the client (Samler, 1962). There seems to be agreement in three areas across several definitions of counselling (Hansen *et al*, 1977; Patterson, 1980; BAC, 1989; McLeod, 1993; Thompson, 1995; Corey, 1996).

a) Counselling (and psychotherapy) as a process.

b) Counselling as practised on a professional basis.

c) Counselling as provided by a trained person.

a) Counselling as a process

The Concise Oxford dictionary defines process as "a course of action or a procedure" (Thompson, 1995:1090).

> "Counselling is a **process** that involves teaching clients how to deal with their problems and find their own solutions based on their value system." (Corey, 1996:22)

> "Counselling is the **process** of assisting and guiding clients, especially by a trained person on a professional basis, to resolve especially personal, social, or psychological problems and difficulties." (Thompson, 1995:305)

> "Counselling is a **process** involving a special kind of relationship between a person, who asks for help with a psychological problem (the client or the patient), and a person, who is trained to provide that help (the counsellor or the therapist)." (Patterson,, 1980:1)

> "Counselling is a **process** of establishing a co-operative relationship and then using that interpersonal interaction to help the client learn his or her desired appropriate behaviour." (Hansen et al, 1977:239)

b) Counselling as practised on a professional basis

Counselling is different from any other ordinary human relationships (Rogers, 1942; Brammer *et al*, 1993). It is a professional relationship and is practised professionally, or on a professional basis.

> "Counselling is to give advice to (a person) on social, psychological, or personal problems, especially **professionally.**" (Thompson, 1995:305)

> "Counselling is the process of assisting and guiding clients, especially by a trained person on a **professional** basis, ..." (Thompson, 1995:305)

> "Counselling denotes a **professional** relationship between a trained counsellor and a client."[15]

c) Counselling as provided by a trained person

At the moment, anyone can offer their services by describing themselves as counsellors with or without counselling qualifications. There is no doubt that a large number of people throughout the UK are offering private counselling services and are not qualified or accredited. This might lead to a danger that counselling could be misused and, subsequently, the client might be damaged when the therapeutic intervention required in the counselling situation is outside the individual's competence. Therefore, it is of fundamental importance that a trained person should provide this service.

> "Counselling is a process involving a special kind of relationship between a person, who asks for help with a psychological problem (the client or the patient), and a person, who is **trained** to provide that help (the counsellor or the therapist)." (Patterson,, 1980:1)

> "Counselling denotes a professional relationship between a **trained** counsellor and a client .." [16]

3.2.2. Areas of difference

Despite the agreements described above, there appear to be four differences in their definitions of counselling.

a) Client-centred versus advice-giving aspects

b) Dimensions of the counselling relationship

c) Aims of counselling intervention

d) The role of counsellors

[15] Cited by McLeod 1993:1, counselling definition by Burkes and Stefflre 1979:14

[16] Cited by McLeod 1993:1, counselling definition by Burkes and Stefflre 1979:14

a) Client-centred versus advice-giving aspects

The first main difference in definitions of counselling rests on the definitions provided by the British Association for Counselling (BAC) and the Concise Oxford Dictionary. While the BAC's definition is mainly client-centred, the common dictionary definition focuses on a more directive approach that "counselling is to give advice to (a person)..." or "counselling is the process of assisting and guiding clients,..." (Thompson, 1995:305).

b) Dimensions of the counselling relationship

The previous chapter stresses that counselling is a relationship consisting of various dimensions (Hansen *et al*, 1977). The second difference rests on the distinct elements of relationship specified in their definitions.

> "Counselling denotes **a professional relationship** between a trained counsellor and a client." [17]
>
> "Counselling is **the skilled and principled use of relationship**...." (BAC, 1989:1)
>
> "Counselling is a process of establishing **a co-operative relationship**....." (Hansen et al, 1977:239)

As discussed in Chapter Two, most approaches to counselling and therapy regard the client-counsellor relationship as the most significant aspect of counselling (Hansen *et al*, 1977; McLeod, 1993; Hough, 1994). Furthermore, regardless of which model of counselling is being used, the operating relationship between client and counsellor is of fundamental importance to the success of the therapy in progress (Brammer *et al*, 1993; Hough, 1994). However, it is not clear whether the main focus of these three definitions is on the distinct elements of relationship described above (professional, skilled and principled use or co-operative) or on the relationship itself.

> "Counselling denotes a professional **relationship** between a trained counsellor and a client.." [18]
>
> "Counselling is the skilled and principled use of **relationship**...." (BAC, 1989:1)
>
> "Counselling is a process of establishing a co-operative **relationship**....." (Hansen et al, 1977:239)

On the one hand, the types of relationship are specified involving person-to-person or more than two people.

> "Counselling denotes a professional relationship between a trained counsellor and a client. This relationship is usually person-to-person, although it may sometimes involve more than two people." [19]

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[17] Cited by McLeod 1993:1, counselling definition by Burkes and Stefflre 1979:14
[18] Cited by McLeod 1993:1, counselling definition by Burkes and Stefflre 1979:14

On the other hand, the British Association for Counselling describes the involvements in the relationship.

> "Counselling is the skilled and principled use of relationship to facilitate self-knowledge, emotional acceptance and growth, and the optimal development of personal resources.... Counselling relationships will vary according to need but may be concerned with developmental issues, addressing and resolving specific problems, making decisions, coping with crisis, developing personal insights and knowledge, working through feelings of inner conflict, or improving relationships with others." (BAC, 1989:1)

Despite the types of relationship and the involvements of the relationship, Hansen *et al* emphasise the notion of establishing a co-operative relationship.

> "Counselling is a process of establishing a co-operative relationship and then using that interpersonal interaction to help the client learn his or her desired appropriate behaviour." (Hansen et al, 1977:239)

c) Aims of counselling intervention

It was argued in Chapter Two that counselling is claimed to be effective in achieving certain aims and goals. Patterson (1980) suggests that, to a greater or lesser extent, all counsellors expect their clients to change - in attitudes, feelings, perceptions, values, or goals - as a result of their particular methods or techniques. The third area of difference between definitions of counselling is placed on the aims of counselling intervention which emphasising the teaching aspect, the satisfaction of client's life, and clients learning to reach their self-determined goals and their desired appropriate behaviour.

> "[The aim of counselling is] .... teaching clients how to deal with their problems and find their own solutions based on their [own] value system." (Corey, 1996:22)

> ".... The overall aim is to provide an opportunity to work towards living more satisfyingly and resourcefully...." (BAC, 1989:1)

> ".... It is designed to help clients to understand and clarify their views of their lifespace, and to learn to reach their self-determined goals through meaningful, well-informed choices and through resolution of problems of an emotional or interpersonal nature".[20]

> "[The aim of counselling is] using that interpersonal interaction [the co-operative relationship] to help the client learn his or her desired appropriate behaviour." (Hansen et al, 1977:239)

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[19] Cited by McLeod 1993:1, counselling definition by Burkes and Stefflre 1979:14

[20] Cited by McLeod 1993:1, counselling definition by Burkes and Stefflre 1979:14

d) The role of counsellors

The role of counsellors was described in chapter two as being "expert" by psychoanalysists, "teacher" by Adlerian therapists, or "teacher", "advisor", or "reinforcer" by behavioural counsellors. The fourth difference between definitions of counselling resides in the fact that the majority do not address the role of counsellors. However, the British Association for Counselling (BAC) specifies that the role of counsellors is within the humanistic tradition.

> ".... The counsellor's role is to facilitate the client's work in ways that respect the client's values, personal resources, and capacity for self-determination". (BAC, 1989:1)

Are these definitions sufficient for the argument that counselling may allow for an approach that supplements medical care and health education in responding to the threat of HIV infection and AIDS? Can the definitions of HIV/AIDS counselling accommodate the practice and theory of counselling?

3.3. Definition of HIV counselling by the World Health Organisation

The World Health Organisation (WHO, 1990) places high priority on developing strategies to prevent and control infection with HIV, in which information, education and communication (IEC) play a fundamental role. Counselling is recognised by the WHO as a vital part of an overall IEC-based strategy. Moreover, a number of authors emphasise the importance of AIDS counselling and HIV prevention through health education (Homans & Aggleton, 1988; Green, 1989; Bor & Miller, 1990; Burnard, 1992a; Porche *et al*, 1992). This has also been recognised by many health workers, health departments, and non-governmental organisations. Bor and Miller (1990), Burnard (1992a), Yogev and Connor (1992), and Sketchley (1993) all give significance to the WHO's definition of HIV counselling that counselling could legitimately include education and advice in the context of HIV/AIDS.

This is in line with the notion of Adlerian therapy and behavioural counselling mentioned in the previous chapter. According to Adlerian therapy, the counsellor's role is, among other things, a teaching one, with the emphasis on re-educating clients whose life goals and assumptions may be dysfunctional and mistaken. Generally, a behavioural counsellor is active in counselling sessions. The client learns, unlearns, or relearns specific ways of behaving. Thus, there is a definite educational direction in behavioural counselling, and clients are taught skills that enable them to

manage their lives more effectively. The counsellor may function as a consultant, teacher, advisor, reinforcer, or facilitator.

The WHO's Global Programme on AIDS in Geneva defines HIV counselling as:

> "an ongoing dialogue and relationship between client or patient and counsellor with the aims of preventing transmission of HIV infection and providing psychosocial support to those already affected. In order to achieve these objectives, counselling seeks to help infected people make decisions about their life, boost their self-confidence, and improve family and community relationships and quality of life". (WHO, 1990:10)

This definition highlights the aims of HIV counselling - primarily about prevention and secondly about psychological support. This suggests that the WHO's recommendation is directive in its approach and is based mainly upon behavioural psychology. This is also in line with the common dictionary definition of counselling that "counselling is to give advice to (a person)..." or "counselling is the process of assisting and guiding clients,..." ".... on social, psychological, or personal problems..." (Thompson, 1995:305).

Thus, the WHO's definition of HIV counselling does accommodate the practice and theory of counselling for two reasons.

1. HIV counselling involves a relationship
2. Debate about HIV counselling and the aims of counselling

3.3.1. HIV counselling involves a relationship

In line with Burkes and Stefflre,[21] the WHO's definition emphasises HIV counselling as a "relationship between client or patient and counsellor" (WHO, 1990:10). This is in agreement with most approaches to counselling and therapy mentioned in the previous chapter in two ways. They all believe that:

a) the client-counsellor relationship is the most significant aspect of counselling (Hansen *et al*, 1977; McLeod, 1993; Hough, 1994); and
b) regardless of which model of counselling is being used, the working relationship between client and counsellor is of fundamental importance to the success of the therapy in progress (Brammer *et al*, 1993; Hough, 1994).

[21] Cited by McLeod 1993:1, counselling definition by Burkes and Stefflre 1979:14

However, despite the above agreement with most approaches to counselling, this definition contains a paradox that is worth noticing. As mentioned before, this definition is directive in its approach and is based mainly upon behavioural psychology. Although behaviour counsellors are often described as active and directive, a good client-counsellor relationship is generally regarded as essential. However, it is important to bear in mind that the nature of the client/counsellor relationship is not usually highlighted in any of the literature that describes behavioural approaches.

It was argued in the previous chapter that the humanistic approaches placed the client-counsellor relationship at the centre of counselling. Defining HIV counselling as "an ongoing dialogue and relationship between client or patient and counsellor with the aims of preventing transmission of HIV infection and providing psychosocial support" weakens its behavioural orientation. Yet, this suggests that its approach is eclectic. Is a directive or teaching approach consistent with person-centred counselling? As argued in the previous chapter, eclecticism could be associated with muddle and confusion; it may be necessary to stick to one consistent approach.

3.3.2. Debate about HIV counselling and the aims of counselling

The WHO's definition highlights the aims of HIV counselling as primarily about HIV/AIDS prevention and secondarily about psychosocial support. This implies strongly the directiveness of HIV counselling and its behavioural approach. There have been disagreements about these aims as follows:

a) debate about directive counselling deterring people from returning to counselling;
b) debate about directive counselling involving little sympathy with clients;
c) debate about setting the prevention aspects of HIV counselling before psychological support;
d) debate about counselling being the prevention of HIV infection; and
e) debate about directive counselling as psychological support.

a) Debate about directive counselling deterring people from returning to counselling

Balmer (1992) fears that directive counselling, in the context of HIV/AIDS as defined by the WHO, may have the effect of deterring people from returning to counselling when they want to

explore issues in a non-directive way. However, it is important to bear in mind that the threat of AIDS may lead to individuals' making an immediate and urgent cry for help. Thus, it is possible that many clients who come for counselling are simply not interested in an introspective or explorative approach to their problems which is more time-consuming; but prefer more immediate and direct means of tackling issues that cause them concern. Kiemle (1994) suggests that in working with people with HIV/AIDS, especially in the context of the physical symptoms which indicate that individuals are likely to become ill and deteriorate, the counsellor sometimes needs to direct actively, as opposed to staying with the client's anxiety and waiting for him or her to find a new way of bringing about change.

b) Debate about directive counselling involving little sympathy with clients

For Balmer (1992), a disadvantage of the directive approach is that little sympathy would be granted to somebody who engaged in high risk behaviour and who persistently refused to change attitude and behaviour. Balmer worries that this often leads to the individual's particular needs being ignored. The individual's emotions of anger, bitterness, revenge, fear and resentment need to be addressed in counselling (Balmer, 1992).

However, the individual may not possess the ability to develop his or her full potential alone without much assistance. Therefore, counsellors may have an important role to play here. Although it is inevitable that counsellors may judge the behaviours, attitudes, or standards of their clients, they do not judge the clients themselves. McGowan & Schmidt (1962) propose that counsellors not only should be aware of and have a right to hold their own moral attitudes and values, but should sometimes express them in the counselling relationship (see more details in section 3.4). They argue that this is consistent with Rogers' client-centred approach. Stressing that counsellors should be themselves in the therapeutic relationship, Rogers (1942) suggests that counsellors should express their own feelings as they are experiencing them. However, this act challenges Rogers' notion of "unconditional positive regard" when counsellors are holding negative attitudes towards their clients.

c) Controversy about setting the prevention aspects of HIV counselling before psychological support: A source of disagreement

In Bond's national survey (1991) of HIV counsellors, the majority using client-centred therapy were uneasy with the WHO's definition that set the prevention aspects of HIV counselling before psychological support. They expressed a fear that this could contribute to further misunderstanding about the way counsellors work. This argument implies strongly the exclusiveness of a client-centred counselling approach and disregards the existence of other approaches (see an overview on different approaches to counselling in chapter two).

It is clear that the WHO's definition is consistent with the concept of counselling as discussed in Chapter Two in two ways.

- Counselling claims to be effective in achieving certain aims and goals. The WHO's definition highlights the two aims of HIV counselling as primarily about HIV/AIDS prevention and secondarily about psychosocial support.
- Unlike the psychodynamic and person-centred approaches to counselling that both place a great deal of emphasis on exploration and understanding, this definition is more consistent with the concepts of behavioural psychology, such as the cognitive-behavioural approach. Apparently, the aims in this definition give the impression that they are less concerned with insight or self-actualisation but more oriented towards client action to produce change.

d) Debate about counselling being the prevention of HIV infection

It has been noted that the two aims in the WHO's definition of HIV/AIDS counselling were derived from the medical response to the pandemic. According to the WHO, the first aim of counselling is the prevention of HIV infection. Counselling was introduced during the second stage of the AIDS pandemic when epidemiological evidence had established that the transmission routes were primarily affected by human behaviour. It is true that HIV is not as contagious as other well-known viruses and does not seem to be transmissible through casual social contacts. Given this evidence, it might be possible to prevent the further spread of the virus (Balmer, 1992; Boland, 1992; AIDS Care Education and Training, 1992/3; Sherr, 1995a; Sobo, 1995; Mertens & Low-Beer, 1996; Purvis, 1996).

Balmer compares counselling for sexually transmitted disease (STD) and AIDS since they both share the similarity that the transmission routes are primarily affected by human behaviour (Dixon, 1990; Balmer, 1992). Counselling has not been effective in changing sexual behaviour among STD patients; and even where cures have been discovered for STDs, it has made little difference (Balmer, 1992). While the prime transmission route is the result of sexual behaviour (in STDs), the prevention of infection is theoretically possible, however, rarely achieved. For Balmer, there is little reason to believe that the HIV/AIDS pandemic is any different. Despite the similarity, Balmer's argument here seems to disregard the differences between STDs and HIV/AIDS. This will be discussed later in section 3.5.2a.

e) Debate about directive counselling as psychological support

The second aim in the WHO's definition of counselling is to provide psychosocial support for those who are infected, together with their spouse, carer, family, employer or community.

Balmer claims that people persist in high risk behaviour even after directive counselling. A number of studies focus on the ethical issues regarding people with HIV/AIDS refusing to change behaviour (i.e. Harding *et al*, 1993). However, these authors fail to report if this is the direct result of receiving directive counselling. Balmer argues that behaviour change is best achieved by creating a supportive social climate that promotes change by recognising that everybody is at risk and everybody needs support (also Bor *et al*, 1988; Dworkin & Pincu, 1993). Yet, this argument creates confusion and misunderstanding regarding the nature of the infection which is primarily affected by human behaviour and is preventable to a large extent. Therefore, it is necessary to pronounce the three main routes of HIV transmission (though sexual contact, infected blood, and vertical transmission) regarding the risk of infection.

First, the risk of HIV infection through sexual contact depends on a number of factors.

1) The risk of HIV infection resides in the probability that a sexual partner is HIV-infected. Sticking to one partner will not offer protection against HIV if that partner is infected (Macklin, 1989). When a sexual partner is HIV infected there is a high risk of HIV infection through sexual contact; thus, non-promiscuity does not guarantee that one will not contract HIV (Cumbleton, 1985).
2) The risk of HIV infection relies on the clinical status of the partner (Macklin, 1989). Walker (1991) reports that infectivity of persons living with HIV varies over the course of the

disease. It is thought that infectivity may be elevated in the early phase of infection and again when opportunistic infection signifies the onset of AIDS (Walker, 1991; Thompson, 1996); at other times, infectivity may remain low (Walker, 1991). This variation of infectivity may in part explain why some people have had years of sexual contact with an infected partner and remained uninfected (Thompson, 1996), while others are infected after one or two contacts (Walker, 1991).

3) The risk of HIV infection is dependent on the presence of genital lesions in either partner with HIV. If a person is infected with STDs, the small wounds by these germs can become easy routes into the body for HIV (Macklin, 1989; Dixon, 1990).
4) The risk of HIV infection rests on the number of sexual partners an infected individual acquires. Anderson & May (1987) suggest that it is significant to know how frequently individuals acquire new sexual partners. They warn that the more new partners an HIV infected individual acquires, the more likely they are to pass on the infection to their partners. Yet, if an individual is not HIV infected, it is possible to have multiple sexual partners who are not HIV infected and have no risk of contracting HIV.
5) The risk of HIV infection depends upon the type of sexual activity (Macklin, 1989). Miller (1987) recommends a significant classification of risk activities but not risk groups. That is, sexual behaviours but not sexual orientation, increase or decrease the risk of acquiring HIV infection. Thus, it can be spread from male to female, female to male, and male to male (Macklin, 1989). Although it is extremely rare, female-to-female transmission has been reported (Macklin, 1989).

The second important route of HIV transmission is by direct exposure to infected blood from an infected person in two manners.

a) The risk of HIV infection relies on the transfusion of HIV-contaminated blood or blood components (Connor, 1986; Gallo, 1987). In the early 1980s, HIV infection was spreading among the haemophiliac population before systematic screening of HIV was secured in all blood transfusions in developed countries.
b) Injecting drugs does not itself lead to HIV infection; sharing contaminated needles does (Amaro, 1993; Bauman, 1995; Berger, 1995). In the UK, the majority of women with HIV infection are injecting drug users or their partners are injecting drug users (Bury, 1992). The greatest number of new infections in 1992 was likely to be in the drug addict population of every city and town in both the United Kingdom and the United States (Dixon, 1990). In Scotland, intravenous drug use is the biggest risk factor for HIV (Berger, 1995).

Third, most children with AIDS have acquired HIV infection from infected mothers by three routes of transmission (WHO, 1987; Canosa, 1991):

a) transmission before delivery, through the placenta, which passes the virus to the unborn baby (Canosa, 1991; Goedert *et al*, 1991);
b) transmission during delivery through exposure to infected maternal blood and vaginal fluids during labour and delivery (Canosa, 1991; Ehrnst *et al*, 1991; Goedert *et al*, 1991); and
c) transmission after birth due to ingestion of breast milk containing the virus (Peckham & Newell, 1990; Canosa, 1991; Finger, 1992; Kennedy *et al*, 1992; Martino *et al*, 1992).

The three main routes of HIV transmission above suggest that HIV infection is preventable and the need for accurate information about transmission and prevention of HIV. This requires a directive counselling style. It has been suggested in chapter one that personal vulnerability to HIV infection increases with a lack of accurate, relevant and comprehensible information about HIV, and when the individual lacks the power or confidence to sustain or implement behaviour changes (Mann *et al*, 1992). In order to reduce personal vulnerability to HIV infection, counselling should emphasise education components. Skills development for safer sex practice, proper use of condoms, or needle hygiene in counselling are behavioural or cognitive behavioural by nature. It is obvious that Rogers' three core conditions - congruence, unconditional positive regard, and empathy - are not sufficient for therapeutic change. Therefore, it is important that counselling includes health education, especially for people who are HIV positive.

3.4. Values in HIV counselling

It has been discussed that HIV infections are primarily affected by human behaviours. Thus, can a HIV/AIDS counsellor be value free? It is generally accepted in counselling that counsellors should not express negative value orientation or disapproval. That is, condemnation of anything the client says or does, has done, or will do. However, does this apply to HIV/AIDS? Two questions are raised for discussion.

1. Are HIV infections preventable through behaviour change?
2. Can HIV counselling be value free?

3.4.1. Are HIV infections preventable through behaviour change?

Does all counselling aim at behaviour change, directly or indirectly? Counsellors deal with behaviour. They work with clients who display behaviour that is more or less disturbed, abnormal, or unsatisfactory in some respects, either to themselves or to society or to both (Patterson, 1980). This promotes an important issue that the nature of the client's behaviour is regarded as the primary focus and concern by the counsellor.

According to Patterson (1980), different approaches to counselling vary in the specific nature and extent of behaviour change, but they all accept behaviour change of some kind, including changes in attitudes, feelings, perceptions, values, or goals, as the objective of counselling. Thus, all therapies and therapists expect their clients to change - in attitudes, feelings, perceptions, values, or goals - as a result of their particular methods or techniques, although this expectation may vary in its degree from highly optimistic to minimal.

Is behaviour change in HIV counselling a more direct aim? Sikkema & Kelly (1996) suggest that HIV infections are preventable through behaviour change. However, Balmer (1992) criticises the directiveness of the WHO's HIV counselling. He argues that this approach is effective when it is possible to determine what behaviour needs to be changed and how it is to be achieved. Thus, it is not certain, for Balmer, how high risk behaviour should be changed. Therefore, it is necessary to acknowledge the three main routes of HIV transmission that are preventable through behaviour change.

a) HIV infection through sexual contact

The first risk of HIV infection is through sexual contact. It was reported before that the risk of HIV infection dwells in the probability that a sexual partner is HIV-infected. It was argued that sticking to one partner will not offer protection against HIV if that partner is infected. Therefore, HIV infections are preventable through adopting safer-sex practice when a sexual partner is HIV-infected.

The risk of HIV infection through sexual contact is reduced through the correct use of condoms during sexual intercourse (Macklin, 1989). The majority of the respondents in studies by Brewin and Gunter (1988), White *et al* (1988, 83%), Galt *et al* (1989, 98%), and Kaul and Stephens

(1991, 98%) all agree on the importance of AIDS prevention through the use of a condom during sexual intercourse.[22] However, several researchers (Sherr, 1989; Squire, 1993; Sobo, 1995) argue that the fear of HIV/AIDS is not related to the intention to use condoms or actual use of condoms. Dixon (1990) warns that condoms may not be as safe as people think they are when they come to reliably preventing pregnancy. He points out that condoms on sale which do not have a BSI kitemark can have up to 7 out of 10 with holes in or other faults in a packet. Important brands, even with a kitemark, have an average of 3 in 100 with holes when they leave the factory. Durex are the best, with only around 1 in 200 with a hole (Dixon, 1990).

b) HIV infection through infected blood

The second risk of HIV infection is through blood transfusion or needle exchange. HIV infection is preventable through screening blood donations and using clean needles. While systematic screening of HIV has been secured in all blood transfusions in developed countries, the greatest number of new infections is likely to be in the drug addict population that regularly share needles.

Bauman (1995) reports Stimson's[23] statement that in Britain, pharmacies and more than 250 agencies distribute clean needles to intravenous drug users (IVDUs), and between 6 and 8 million syringes a year are distributed to 100,000 regular injectors. Before 1987, 60% of IVDUs regularly shared needles, now the figure is between 10 and 15% (Bauman, 1995). However, Bauman fails to report if this distribution of clean needles has had a significant influence in decreasing the rate of HIV infection among IVDUs. Nevertheless, Bauman (1995) reports ethical, moral, and political problems in this. Many doctors, clergy or politicians are opposed to the idea of giving addicts needles or drugs. They perceive two disadvantages with such strategies (Bauman, 1995).

- Distribution of clean needles to IVDUs is encouraging drug injection.
- Distribution of clean needles to IVDUs may be cheap, but it may discourage clients from enrolling in more comprehensive drug treatment programmes.

There are better ways to help drug users who are living in poverty than distributing clean needles.

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[22] Brewin & Gunter (1988) studied 126 media professionals.
White et al (1988) studied 200 14- & 15-year-old secondary school students.
Galt et al (1989) studied 766 18- & 19-year-olds.
Kaul & Stephens (1991) studied 792 18-20-year-old university students.

[23] Gerry Stimsom is the director of the London-based Centre for Research on Drugs and Health Behaviour.

c) HIV infection through vertical transmission

The third risk of HIV infection is from infected mothers to babies. Thus, prevention of paediatric AIDS is dependent upon preventing infection in the mother (WHO, 1987).

3.4.2. Can HIV counselling be value free?

It is common knowledge that the decisions each person makes, the activities of his or her life, and the goals that are established are reflections of values (Hansen *et al*, 1977). A value can be defined as:

> "the worth, desirability, or utility of a thing, or the qualities on which these depend." (Thompson, 1995:1549)
> "one's principles or standards; one's judgement of what is valuable or important in life." (Thompson, 1995:1549)
> "an enduring belief that a specific and end-state or mode of conduct is preferable." (McLeod, 1993:158)
> "a firm, conscious, or unconscious belief in the worth of an idea or feeling." (Brammer & Shostrom, 1982:409)

However, can counsellors express their own value orientation to their clients? Each individual has values, merely by being living human beings. Counsellors' attempts to appear to be neutral as regards social and ethical standards may lead to the danger of appearing not only to accept the client's unethical or immoral behaviour, but of approving it. Counsellors can freely be themselves, without guilt about doing so, or without feeling that they should not have any feelings. This contributes to the openness of the counselling relationship, without violating its client-centredness. Thus, counsellors should not strive to be amoral, ethically neutral individuals. Such a goal would be impossible to achieve. The counsellor does not attempt to manipulate the client in the counselling process. He or she does it simply by being himself or herself.

> "Counselling may be defined as a search for **values** because the search reflects the development of personal **values** both intrinsically and authentically" (Hansen et al, 1977:515).

Therefore, counsellors are simply not value-neutral, nor are they value-free (McGowan & Schmidt, 1962; Patterson, 1980; Corey, 1996) especially in responding to HIV/AIDS. Three major points are discussed.

a) HIV transmission through sexual contacts

Can a counsellor offer unconditional acceptance if an antibody positive person continues unprotected sexual activity with an unsuspecting partner? Individuals may have already

experienced the loss of friends and lovers from AIDS prior to discovering their own HIV-positive status (Kiemle, 1994). Many individuals have been infected by someone who kept their HIV status secret, even though it is important to bear in mind the possibility that many people with HIV/AIDS take precautions and are conscientious about the potentiality of transmitting the virus to others. Many people are infected without known or acknowledged risk factors.

Sobo (1995) refers to this "Betrayal Narrative" as many HIV positive women were infected by their partners who kept their HIV status secret. They tell of broken trust in partners who must not have really loved them. Cantacuzino (1995) interviewed women who were HIV positive. They also felt betrayed by partners who kept their HIV status secret and consequently infected them. Furthermore, at the Johns Hopkins Hospital, while reporting no risk factor for HIV infection, about half of the pregnant women were found to be seropositive after voluntary testing (Hutton & Wissow, 1991). This indicates that many women without known or acknowledged risk factors are infected and are bearing infected children.

Fennema *et al* (1998) recently investigated the potential for ongoing HIV transmission through sexual contact. They found that almost none of the HIV-infected heterosexuals and about half of the HIV-infected homosexual men were not aware of their current serostatus. This might suggest that respondents did not perceive themselves at risk for HIV infection, as none of the HIV-infected heterosexuals reported ever having sex with a person known to be HIV infected. Moreover, HIV-infected heterosexuals (n = 312) reported at least 900 partners in the last 6 months, and HIV-infected homosexual men (n = 239) at least 2,500 male partners. The results stressed a need for notification of sexual partners of HIV-infected individuals.

By the end of 1995, and following an extensive country-by-country review of HIV/AIDS data, a cumulative total of 6 million AIDS cases were estimated to have occurred in adults and children worldwide and currently 20.1 million adults are estimated to be alive and infected with HIV or have AIDS (Mertens & Low-Beer, 1996). Can a counsellor overlook the client's responsibility in preventing further infections and further deaths?

b) HIV transmission through blood transfusion

Can counsellors offer unconditional acceptance if they know that an antibody positive person goes abroad to sell blood, plasma, sperm, or even organs, or shares needles with other drug users. Does the counsellor have an obligation to inform others?

Connor (1986) suggested that there were about 5,000 haemophiliacs in Britain and around 2,000 of them regularly used Factor VIII. Blood tests on these 2,000 showed that 44% of them had antibodies to the virus and had been infected by it. Transfusion of infected blood or blood products was an important mode of transmission in HIV infants and children who were not vertically infected. For instance, in the Netherlands, a single donation from a healthy adult found to be HIV positive was administered to 9 infants (Peckham & Newell, 1990). All 9 infants became infected: 2 have died of AIDS and 3 have AIDS Related Complex (ARC). Many children, especially in Romania[24] (or Russia), seem to have acquired HIV infection through transfusion of unscreened blood and many other children have acquired HIV infection in the medical setting via therapeutic injections through the improper re-use of non-sterile needles and syringes.

The drug addict population is difficult to estimate (Dixon, 1990). According to Denise Paone of Beth Isreal Medical Centre in New York, more intravenous drug users (IVDUs) live in New York than in any other city in the world; about 200,000 people are IVDUs and half of them are HIV-positive (Bauman, 1995).

Can a counsellor emphasise the client's individuality to make choices without any concern for others' safety?

c) HIV transmission from mother to infant

Can a counsellor offer unconditional acceptance if an antibody positive woman decides to risk the possibility of vertical transmission and decides to get pregnant - even after having delivered an infected child? Huggins *et al* (1991) reported pregnancy rates among women who knew their HIV positive status were similar to those who are seronegative, and that pregnancy decisions did not depend on HIV serostatus. Sherr (1991ab), Boland and Harris (1992), and Sanford & Vosmek (1993) found that many seropositive women continued their pregnancy and often had subsequent pregnancies. They recommended the need to examine a broad range of input covering

[24] Many children in hospital in Romania received one or more blood transfusion as some local physicians believed that transfusions of whole blood would provide important nutrients to sick malnourished children, and help stimulate their immune systems (Hersh *et al,* 1991).

contraception advice, involvement of women and their partners, and help in examining self fulfilment avenues for women who often find childbearing to be their primary self fulfilment role.

The transmission of HIV from the mother to the baby is currently estimated at 20 or 30%.[25] Sanford & Vosmek (1993) agree with Boland *et al* that for a woman living in poverty in an urban centre, where violence, crime and drug addition are a daily occurrence, a 70% probability of giving birth to a healthy baby seems optimistic. Boland and Harris (1992) suggest that HIV positive women who choose to continue their pregnancies often do so because of a desire for a child, religious beliefs and family pressures. For some, the 30% risk of transmission is seen as a positive outcome. Despite knowledge of potential transmission to future offspring, many women choose to become pregnant and derive increased self-esteem and fulfilment in bearing a child, even after having delivered an infected child. For others, the possibility of bearing a healthy infant may provide them with a legacy to their own short lives. It is something they may leave behind - something good and wonderful despite a life of poverty and pain. Boland and Harris report that for some mothers, such a pregnancy may be an attempt to fill the emptiness left by the death of a child with AIDS.

However, children are not the possessions of their parents or mere means to satisfaction of parental desires (Arras, 1990). A 20 to 30 per cent chance of exposing children to HIV infection is simply too high. By the year 2,000, ten million infants and children worldwide will be infected with HIV and most of them will die before their fifth birthday (Yogev & Connor, 1992). More than half of the children will die before the age of five, even though some will live longer - perhaps to the age of ten or beyond (Arras, 1990; Mok, 1991). The implication is that they will live under a cloud of impending death with progressively deteriorating immune systems. In contrast to most genetic diseases, Arras (1990) and van den Boom (1995) both emphasise that the diagnosis of AIDS in a child usually signals an entire family at risk. By the time the diagnosis is made, the father is often already sick or dead, and the mother must cope not only with an infected child, but also with the dread of her own approaching symptoms and death. Many parents are too ill to take responsibility for the care of their own children - both infected and normal.

Arras (1990) suggests that the often intense desire of women with HIV/AIDS for children must be modified by an acknowledgement of one's responsibilities as a parent. According to Arras, parents have duties to their children to provide things, such as shelter, nutrition, education, and

[25] Studies reported mother-to-infant transmission rates range from 13% to 40% (Goedert *et al,* 1992), 25% to 40% (Henggeler *et al,* 1992), or of 30% (Sanford & Vosmek, 1993). Roberts (1996) reports the current infection rate among the 2,000 newborns who are positive to the antibody runs at about 20%.

emotional nurturing. Arras feels that it is a good reason not to have children if a person can predict well in advance that he or she will be incapable of discharging these parental duties in the near future. This is especially true in cases where the woman's male partner or extended family is likewise unavailable for parenting. He stresses that in all too many cases, by the time children receive a diagnosis of HIV infection their parents are manifesting severe symptoms, incapacitated by drug use, or are themselves already dead. As a result, they are often incapable of caring for the very children whom they put at risk.

If parents are unable to discharge their responsibilities, foster care and adoption are reasonable and necessary remedies (Arras, 1990). Yet, Arras questions whether parents ought to put themselves and their children into such a position in the first place, knowing that the risk of eventual disconnection and forfeiture of duty is high. Arras believes that the presence of such a risk constitutes a good reason not to have children in the first place, whether or not the children turn out to be infected. Arras suggests that this is an important factor to be weighed in every case, but it should not be in every case a *compelling* reason for reproductive restraint.

Observations on these three issues

Is HIV/AIDS counselling value loaded? The discussion based upon these three points raises a significant observation in relation to Rogers' person-centred approach to counselling. Rogers' client-centred counselling emphasises the important dimension of "self" or "self-actualisation". Humanistic counsellors would agree that client-centred counselling is centred upon "whatever the clients themselves perceive as their problem". There is an assumption that "unconditional acceptance" of the clients will lead to developing their full potential and becoming a "fully functioning person". This assumption overemphasises the uniqueness of individuality.

However, individuals are interdependent within the context of relationships with other individuals. The goal of counselling cannot be limited to the individual or the individual's self-actualisation especially in the context of HIV/AIDS. There is a danger regarding the client-centred approach since the result of this counselling approach may produce a self-centred person with little concern for others (Patterson, 1980). This approach to counselling overlooks the client's responsibility in preventing further infections to others and further deaths.

These three points above raise an important question: should counsellors intentionally seek to bring about in each client decisions or choices which are consistent with what they or society believe, or should they permit the client to make choices according to the client's own values even though such choices are, in the counsellor's estimation, unsuitable or wrong (McGowan & Schmidt, 1962:99)?

The majority of therapies would insist that clients must freely accept or reject such values, and develop or construct their own ethical system or philosophy of life. Client-centred counsellors would respect the client's right to do so, even though the client might choose wrongly or adopt an unethical or immoral course of behaviour when given such freedom, as discussed before. This indicates that the client-centred counsellor will accept the client's free choice of endangering others' lives without judgement.

> "Counselling is a process that involves teaching clients how to deal with their problems and find their own solutions based on their **value system**." (Corey, 1996:22)

However, can a counsellor be value free in the context of HIV/AIDS? What is the right of the individual who has HIV/AIDS? What is the right of individuals to protect themselves against the spread of HIV? Is it the counsellor's duty to protect the third parties? It is generally accepted in counselling that counsellors should not express negative value orientation or disapproval, that is, condemnation of anything the client says or does, has done, or will do. This requirement may mean that counsellors greatly weaken their effectiveness (McGowan & Schmidt, 1962:141). A proposal is raised here that HIV/AIDS counsellors cannot be value-free and HIV/AIDS counselling is a different kind of counselling. The next section elaborates this argument.

3.5. Quality of HIV/AIDS counselling: a different kind of counselling?

There is an on-going debate on whether HIV/AIDS counselling is a different kind of activity from counselling as it is understood in other settings. Because of the relative infancy of HIV counselling, there are few objectives and clear and widely agreed principles to guide either the counsellor, referrer or would-be client. There is confusion about the nature of counselling required not only by people with HIV/AIDS but also among care workers who provide HIV/AIDS counselling. Moreover, there is currently little agreement in the field about what psychological therapies are appropriate, for what clients, and at what stage of the disease progression.

3.5.1. The view that HIV counselling is not a different kind of counselling

"HIV counselling is not a different kind of counselling but is within the scope of the BAC definition" (Bond, 1991:7). This was widely accepted by counsellors in Bond's national survey, who provided on-going counselling for people with HIV/AIDS. They believe that the problems raised in counselling people with HIV/AIDS are quite often those raised by any client group, such as relationships, self-esteem, anxiety, etc..., with the additional complication of HIV infection. Burnard (1992a) agrees with Bond and argues that the skills involved in counselling the person with AIDS are not fundamentally different to counselling anyone without AIDS. However, Burnard (1992a) draws evidence that people with AIDS often have particular problems that can best be helped by someone who has specific skills and knowledge.

3.5.2. The view that HIV counselling differs from counselling people without HIV/AIDS

HIV is a medical condition. Although counsellors are concerned with the emotional life of their clients, it should be remembered that this is always in the context of a series of physical parameters (DiScenza *et al*, 1996; Ratigan, 1997). There seem to be four matters of fact describing the distinctive features of HIV/AIDS counselling compared with other counselling.

a) Two differences between HIV/AIDS and STDs
b) HIV counselling in the context of HIV Counselling and Testing
c) Bereavement issues in HIV/AIDS counselling: multiple losses
d) Counsellors being challenged by HIV/AIDS

a) Two differences between HIV/AIDS and STDs

According to Dixon (1990), sexually transmitted diseases (STDs) have been around for thousands of years, and AIDS can be seen as the latest in a long series of epidemics spread by sex. However, there are two differences between HIV-related disease and other sexual epidemics as syphilis or gonorrhoea that suggest that HIV/AIDS counselling is a different kind of counselling.

- First, HIV can infect people for years before they know it (Sattaur, 1985; Ferry, 1987; Scott, 1987; Green, 1989; Dixon, 1991; Haynes *et al*, 1996), and by the time they do, it has spread to infect others, such as their sexual partners or children.
- Second, once people develop AIDS, which can take many years, they face certain death (Smith, 1986; King, 1989; Arras, 1990; Dixon, 1990; Reidy *et al*, 1991; Kiemle, 1994).

b) HIV counselling in the context of HIV Counselling and Testing (CT)

Sikkema and Bissett emphasise the issue that HIV counselling in the context of HIV CT differs from counselling and psychotherapy in five respects (Sikkema and Bissett, 1997:20). The first difference lies with the issue of anonymity. It is not uncommon for a client to remain anonymous throughout the entire HIV CT process. Many clients might forego testing if anonymity were not assured because of the stigma and discrimination surrounding AIDS (section 1.2.2b). Anonymity, however, may make client follow-up more difficult.

Second, the nature of HIV presents a unique counselling challenge. Clients who test positive for HIV effectively face a terminal situation, despite medical advances that promise eventual long-term management of the infection (section 1.3.1). In addition, anyone infected with HIV can pass these severe consequences on to another. There is no parallel to this complex counselling challenge of: a) simultaneously meeting the emotional support and coping needs of someone dealing with their own mortality, and b) facilitating risk-related behaviour change. This complexity distinguishes HIV CT from other health-related counselling situations, such as physician-mediated counselling for other STDs, high cholesterol, pregnancy, or even cancer.

Third, HIV CT occurs in a wide variety of contexts, including public health departments, STD clinics, drug treatment facilities, mobile outreach services, private physician offices or health maintenance organisations, women's health (prenatal) clinics, hospitals, and community-based AIDS service organisations. A positive aspect of this variety in settings is that populations in need may have better access to HIV CT, arguably resulting in service provision to a higher proportion of those clients at greater risk. However, this wide variety of testing environments presents a challenge to the goal of offering counselling services of comparable components and quality to all clients.

Fourth, client expectations and motivation vary across HIV CT contexts and may be less strong than those found in counselling settings. For example, the motivation of persons seeking repeat testing while in a sexual relationship with an HIV infected individual, will likely differ from persons who are tested as part of a routine medical examination. A few people with HIV infection or even AIDS show no wish to change their behaviour or life-style (Sketchley, 1993; Futterman *et al*, 1990; Cleary *et al*, 1991; DiScenza *et al*, 1996). Unlike those seeking other counselling, clients presenting for HIV CT, especially those who subsequently receive a negative test result, often do not acknowledge any need for counselling.

Fifth, the frequency and duration of counselling also distinguish counselling within an HIV context. HIV CT is generally intended to occur over two brief interactions (pre-test and post-test). Such abbreviated contact may limit the ability of counsellors to interact effectively with their clients.

c) Bereavement issues in HIV/AIDS counselling

The AIDS epidemic has revealed a wave of deaths in a population unused to facing traumatic loss to such an intense extent (Carmack, 1992; Sherr *et al*, 1992). This suggests that HIV/AIDS counselling raises different issues to counselling people without HIV/AIDS.

There are unique features surrounding HIV/AIDS that may differ dramatically from other sorts of loss.

- The bereavements are often multiple and occur in a brief period of time (Carmack, 1992; Sherr *et al*, 1992; Kiemle, 1994; Miller, 1995; Sikkema *et al*, 1995). Sherr *et al* (1992) reported 90 individuals with HIV/AIDS.[26] They had lost 348 people with an average of 12.9 deaths per person. These were overwhelmingly due to AIDS with only 12 (5.6%) not HIV related.
- Care workers, including health professionals, social workers, counsellors, etc., are facing multiple losses of patients (Miller, 1995) - 5 of the multiply bereaved individuals were working in HIV/AIDS help organisations (Sherr *et al*, 1992).
- Those who die are invariably young (Sherr *et al*, 1992; Kiemle, 1994; Miller, 1995; Phillips & Coates, 1995), generally 20 to 40 years old in adults and under 5 in children.
- Often partners - with sexual relationships - or children are jointly exposed to this disease (section 3.4.2c).
- Those who are infected are often the principal carer for others dying from AIDS (Arras, 1990; Sherr *et al*, 1992).
- Those who are infected often link the bereavement to their own death - 65% of them linked the bereavement to their own death. The authors suggest that perhaps for the first time, the bereavement triggers an examination of their own illness, mortality and death (Sherr *et al*, 1992).
- The frequency and high rate of bereavement is often not noted by referrers (Sherr *et al*, 1992).

[26] 44.8% were diagnosed as HIV positive, 42.5% had an AIDS diagnosis and the remainder were coded as AIDS Related Complex or unclear (Sherr *et al*, 1992).

d) Counsellors being challenged by HIV/AIDS

The unique feature in the context of HIV/AIDS counselling that differs from other client groups is that counsellors are working with a client who might be healthy at the beginning of the counselling, then is progressively dying and eventually dies. The combination of disturbing and upsetting challenges, counsellors' obligations, and professional competency all suggest that HIV/AIDS counselling can be distinguished from other counselling.

Disturbing and upsetting challenges

Perhaps more than any other client group, people with HIV/AIDS will challenge counsellors with issues that can be disturbing and upsetting. They can challenge the counsellors to look closely at their own fears and feelings in relation to sex and sexuality, disease, disability, disfigurement, and death and dying (Kiemle, 1994). Another issue which counsellors may not have previously encountered in the therapeutic relationship with other clients is that they may be challenged by the reactions of clients when facing their HIV positive diagnosis. Some individuals fatalistically accept a diagnosis of HIV as a death sentence. Others, even when ill with AIDS, completely deny that they might even have a serious illness.

Counsellors' obligations

Despite the tremendous amount of debate, Harding *et al* (1993) report an emerging ethical theme that distinguishes HIV/AIDS counselling from other counselling. They argue that counsellors (as well as psychologists, psychiatrists, social workers, and physicians) have an obligation to consider the health and welfare of society at large when AIDS clients are involved in unprotected sexual activities and are unwilling to inform sexual partner(s) about their HIV status. This is the crucial difference between HIV/AIDS counselling and many other forms of counselling.

Professional competency

HIV/AIDS counselling stimulates thoughts about professional competency. Kiemle (1994) reported one counsellor feeling burdened and depressed for hours after the client had left. The current shortage experienced in counselling personnel may have contributed to the fatigue and isolation many counselling staff working with people with HIV/AIDS have encountered (Carballo & Miller, 1989). The absence of professional peer support has increased the demands on time, involvement and decision making responsibilities. This intensity at work often leads to 'burnout' that at times contributes to high levels of staff turnover (Carballo & Miller, 1989; Miller, 1995). Most care workers who provide HIV/AIDS counselling in response to the acute and complex

emotional needs of their clients, feel ill-prepared and ill-equipped for this task (see next chapter on the discussion of competency, experience, and training of HIV/AIDS counsellors). Moreover, there is an on-going debate about who should provide HIV/AIDS counselling and about whether counselling is a specialist activity or not (see details on next section 3.6).

3.6. Provision of HIV/AIDS counselling by different care workers

As already discussed, different people interpret counselling differently as a result of the diversity of opinion and practice in counselling. There is an on-going debate about who should provide HIV/AIDS counselling. This debate is concentrated on the issue as to whether counselling is a specialist activity that is best provided by counsellors trained specifically for the task or whether anyone can provide it regardless of the level of training received.

The issue of HIV/AIDS is increasingly becoming the direct concern of all health professionals (Burnard, 1992a; Silverman, 1990; WHO, 1990; Woolfe & Dryden, 1996; Corney, 1997). Many practitioners are committed to the concept of holistic medicine, where attention is paid to the whole person, to psychological and social factors as well as physical illness and difficulties (Corney, 1997). Within the health service, responsibility for providing HIV/AIDS counselling has been assigned to a range of staff. A number of individuals would describe themselves as counsellors in a medical setting. They include doctors, nurses, social workers, psychologists, and specialist nurses.

According to the WHO (1990), in addition to doctors, nurses, psychologists, and social workers, other people can readily be encouraged and trained to provide counselling support. Counsellors need not be formal health care providers; teachers, health educators, religious and community leaders, youth group workers, and members of self-help groups can also provide preventive and supportive counselling (WHO, 1990). Similarly, Green and McCreaner (1989) suggest that HIV/AIDS counselling is not restricted to professional trained counsellors but can be provided by anyone who is working with people affected directly or indirectly by HIV/AIDS.

However, the quality of the counselling service individuals provide varies widely (Silverman, 1990). This variation may be attributed to the diverse backgrounds, training and experience of

those who are responsible for providing HIV counselling. This is discussed in more detail in the next chapter.

3.6.1. The differences between counselling relationships and other relationships

For Rogers (1942), the counselling relationship represents a quality of social bond that differs from any the client has previously experienced. In his book "Counselling and Psychotherapy", Rogers (1942) discusses the differences between counselling relationships and a parent-child relationship, a friend-friend relationship, a teacher-pupil relationship, and a physician-patient relationship.

a) Parent-child relationship

A parent-child relationship is a bond with deep affectional ties; its characteristics are dependence on the one hand, and the acceptance of an authoritative and responsible role on the other. According to Rogers (1942), the therapeutic relationship is not a parent-child relationship. Rogers suggests that the parent-child bond has an undertone of permanence and complete devotion that is not a part of the best counselling.

b) Friend-friend relationship

The therapeutic relationship is not the relationship of friend to friend, either, according to Rogers (1942). In such a bond the outstanding characteristic is complete mutuality - mutual understanding, give and take.

c) Teacher-pupil relationship

Neither is the counselling relationship a typical teacher-pupil relationship. For Rogers (1942), a teacher-pupil relationship has implications of superior and subordinate status, an assumption that one is to teach and the other to learn, and complete reliance upon intellectual processes.

d) Physician-patient relationship

A counselling relationship is not based on a physician-patient relationship. Rogers describes the characteristics of a physician-patient relationship as expert diagnosis and authoritative advice on the part of the physician, and submissive acceptance and dependence on the part of the patient.

The list might be extended. For example, the counselling relationship is not the relationship between two co-workers, although it partakes of certain elements. It is not the relationship of

leader and follower, nor of priest and parishioner. Therefore, the counselling relationship denotes different qualities from any other ordinary relationships in life (Rogers, 1942; Brammer *et al*, 1993).

Brammer *et al* (1993) agree with Rogers that a therapeutic relationship is distinct from other human relationships. They suggest that while friends, relatives, and teachers have profound influences on behaviour, the unique element of a counselling relationship is its structure. It has a carefully planned and described framework (Hansen *et al*, 1977; Patterson, 1980; Thompson, 1995; Corey, 1996). However, they believe that because of its intimate nature, structure, and attitudes, the counselling relationship also has similarities to other human relationships, such as family, friendship, teacher-pupil, doctor-patient, and pastor-parishioner.

Nevertheless, Rogers (1942) questioned whether a therapeutic relationship is compatible with authority, such as teacher, probation officer or court worker, social worker or case worker, personnel or industrial counsellor. Is it possible for these professional workers, who have an interest in problems of individual maladjustment, to create and carry on a counselling relationship? The answer is not a simple one and much thought and much research needs to be done in this field.

3.6.2. Role ambiguity, conflict, and confusion

McLeod (1993) suggests that it is probably not helpful to draw rigid lines of professional demarcation that deny that teachers, nurses, probation officers or social workers can ever be counsellors to their clients. However, McLeod stresses two important issues. First, it is important to recognise that clients can become confused or damaged when the people who are trying to help them become enmeshed in role conflicts through attempting to be counsellors, as well as, for instance, teachers, nurses, or doctors. Second, it can also be damaging for both client and worker if the counselling process moves into areas beyond the training or competence of the helper. Burnard (1992b) recommends that although counselling is a necessary part of the support service offered to people with HIV/AIDS, it is not necessarily a task suitable for nurses.

Conclusions

It is clear throughout the discussion in this chapter that HIV counselling aims at behaviour change. Although counselling constantly appears in AIDS literature as a desirable intervention and is becoming more available, there is little agreement in the field of HIV/AIDS counselling, about what psychological therapies are appropriate for what client groups, and at what stage of the disease progression.

There is neither copyright nor patent on the term 'counselling'. Counselling has been used and misused in all areas of human life. As a result of diversity of opinion and practice, counselling is interpreted differently by different people. Anyone can claim themselves as providing counselling. Efforts to formulate precise comprehensive definitions of counselling have faced great difficulty.

Counselling is perceived to be of fundamental importance to the prevention of HIV infection internationally. The World Health Organisation (WHO, 1990) places high priority on developing strategies to prevent and control infection with HIV, in which information, education and communication (IEC) play a fundamental role, and counselling is recognised as a vital part of an overall IEC-based strategy. This is in line with behavioural counselling. There is a definite educational direction in behavioural counselling, and clients are taught skills that enable them to manage their lives more effectively.

It has been argued throughout this chapter that HIV infection is primarily affected by human behaviour and is preventable to a large extent. However, the individual does not possess the ability to develop his or her full potential alone without much assistance. An experienced counsellor suggests that in working with people with HIV/AIDS, especially in the context of the physical symptoms which indicate that individuals are likely to become ill and deteriorate, the counsellor sometimes needs to direct actively, as opposed to staying with the client's anxiety and waiting for him or her to find a new way of bringing about change.

Counsellors have a potentially important role to play here. Counsellors should not only be aware of and have a right to hold their own moral attitudes and values, but should sometimes express them in the counselling relationship. Although it is inevitable that counsellors may judge the behaviours, attitudes, or standards of their clients, they do not judge the clients themselves. It has been argued that all counsellors deal with behaviour and they all expect their clients to change, to a greater or lesser extent, as a result of their particular methods or technique. These behavioural

changes include changes in attitudes, feelings, perceptions, values, or goals. The argument was discussed in this chapter that counsellors cannot be value-free in the context of HIV/AIDS, and HIV/AIDS counselling differs from counselling people without HIV/AIDS.

Moreover, it was suggested that people persist in high risk behaviour even after receiving HIV/AIDS counselling. It has been argued that counsellors have an obligation to consider the health and welfare of society when their clients posed risk to others. This is the crucial difference between HIV/AIDS counselling and many other forms of counselling. It is clear that there is not only a health education element but also a responsibility to society in the context of HIV/AIDS counselling. However, it is important to bear in mind that those issues also appear in other areas of counselling, such as drug abuse or sex offence. This suggests that HIV/AIDS counselling may not be different to other forms of counselling but its complexity and difficulty appears to present the task in its most extreme form.

Furthermore, there is an on-going debate about who should provide HIV/AIDS counselling and whether this sort of counselling is a specialist activity that is best provided by counsellors trained specifically for this task or whether anyone can provide it regardless of the level of training received. It was suggested that clients could become confused or damaged when the people who attempted to help them became enmeshed in role conflicts, especially when the counselling process moved into areas beyond the training or competence of the helper.

Many counsellors may be ill-prepared to meet the challenge arising from the AIDS epidemic or have very little counselling training or no training. The quality of HIV/AIDS counselling services varies widely. This variation may be due to the diverse background, training, and experience of those who are responsible for providing HIV counselling. The next chapter investigates the effectiveness of HIV/AIDS counselling.

CHAPTER FOUR: EFFECTIVENESS OF HIV/AIDS COUNSELLING

Introduction

Chapter One noted an increasing demand for counselling in responding to the epidemic of AIDS. HIV/AIDS counselling is perceived as important in national and international HIV prevention (WHO, 1990; Rugg *et al,* 1991; Otten *et al,* 1993; Phillips & Coates, 1995; Discenza *et al,* 1996).

However, many counsellors are ill-prepared to meet the challenge arising from the AIDS epidemic or have very little counselling training or no training. The quality of HIV/AIDS counselling service varies widely. This variation might be the result of the diverse background, training, and experience of those who are responsible for providing HIV/AIDS counselling. Therefore, the evaluation of the effectiveness of HIV/AIDS counselling is of fundamental importance.

This chapter focuses attention on the following issues:

1. the nature of HIV antibody testing and counselling;
2. effectiveness of HIV counselling and testing aimed at the prevention of HIV transmission;
3. effectiveness of counselling provision in medical settings; and
4. counselling expertise in care workers who provide counselling to people with HIV/AIDS.

4.1. The nature of HIV antibody testing and counselling

It is obvious from the discussion in the previous chapter that HIV counselling aims at behaviour change. The combination of HIV antibody testing and counselling, both before and after the test, is a key component of the strategy for the prevention of HIV transmission (Otten *et al,* 1993; Phillips & Coates, 1995). Research to examine, understand, and improve the usefulness and effectiveness of HIV counselling and testing (HIV CT) has been difficult and challenging (Sikkema & Bissett, 1997).

4.1.1. HIV antibody testing counselling

HIV counselling includes three phases of counselling in HIV antibody testing: (1) pre-test counselling, (2) post-test counselling, and (3) follow-up counselling (Porche *et al* 1992). In each case the focus is primarily on health care, with psychological support as a secondary factor (WHO, 1990). The World Health Organisation's recommendation for HIV counselling is based on a behavioural approach, as discussed in the previous chapter, and the Centre for Disease Control (CDC) in the USA recommends a similar approach. The CDC recommends that HIV counselling and testing (CT) should consist of client-centred pre-test and post-test counselling, and the use of cognitive-behaviour change plans (Sikkema & Bissett, 1997). The advantages and disadvantages of combining different approaches to counselling have been discussed in Chapter Two. A person-centred approach allows people to be treated in their singularity and uniqueness (Rogers, 1942; Balmer, 1992). This would fit with the wider social context of trying to encourage more supportive attitudes and a more open social climate associated with the pandemic (Balmer, 1992). However, applying a client-centred approach to HIV counselling de-emphasises the provision of education on the part of the counsellor.

a) Pre-test counselling

Counselling that precedes the HIV antibody test is called pre-test counselling. The basic pre-test counselling lasts 2 to 20 minutes (Rugg *et al*, 1991; Otten *et al*, 1993). The pre-test counselling session provides information so the client can make an informed decision about testing. It also provides the client with a safe environment to ask questions, express concerns, and decide whether to proceed with the HIV antibody test or not. Pre-test counselling provides an opportunity (Higgins *et al*, 1991; Porche *et al*, 1992; Otten *et al*, 1993; Sikkema & Bissett, 1997):

- to explain the meaning and limitations of the HIV antibody test,
- to assess the client's knowledge of HIV,
- to discuss the various routes of HIV transmission,
- to provide the client with basic information on HIV prevention,
- to help clients assess their risk behaviours,
- to provide information about risk reduction,
- to discuss ways of changing behaviour that could result in HIV transmission,
- to address the need for HIV antibody testing,

- to explain the procedure for HIV antibody testing, and
- to offer the HIV test.

b) Post-test counselling when the result is positive

Counselling that follows HIV antibody testing is called post-test counselling. The basic post-test counselling lasts 20 to 30 minutes (Rugg *et al,* 1991), or 45 minutes (Otten *et al,* 1993). Post-test counselling starts with breaking the news of the HIV antibody test, then it puts a great emphasis on AIDS health education and prevention. Post-test counselling is concerned with (Green, 1989; Higgins *et al,* 1991; Burnard, 1992a; Porche *et al,* 1992; Otten *et al,* 1993; Sikkema & Bissett, 1997):

- informing the client of test results,
- reinforcing the risk reduction plan,
- encouraging or reinforcing behaviour change,
- providing a starting point for partner notification and education,
- helping with practical problems (such as housing, welfare benefits, etc.),
- offering emotional support, and
- making appropriate referrals.

c) Follow-up counselling

Porche *et al* (1992) suggest that follow-up counselling should be offered to all clients tested, especially to clients who are HIV positive. Yet, Sikkema & Bissett (1997) suggest that multiple post-test counselling sessions are not routinely provided, but should be arranged at referral for clients who may require them. Referral needs differ from client to client but generally fall into three major categories (Sikkema & Bissett, 1997):

- assistance in changing risk behaviour,
- emotional support and coping with HIV, and
- treatment for HIV disease, chemical dependency, and/or other sexually transmitted diseases (STDs).

Considering the CDC HIV CT guidelines, Sikkema & Bissett have delineated HIV counselling into five tasks: relationship building, risk assessment, dissemination of information, behaviour change, and emotional and coping support (Sikkema & Bissett, 1997: 14, 21). Sikkema & Bissett recommend that these tasks may occur in any phase of HIV counselling but are usually associated with a particular phase. For example, relationship building, risk assessment, and

dissemination of critical information occur primarily within pre-test counselling. Behaviour change, on the other hand, occurs in all phases of counselling, whereas emotional coping and support occur primarily within post-test counselling, and then primarily for clients receiving a positive test result.

The authors suggest that the behavioural and cognitive-behavioural approaches adequately address all five tasks. However, they fear that the rationality of these approaches might de-emphasise emotional factors which play a role in developing the therapeutic relationship and providing emotional and coping support. They suggest that a psychodynamic approach offers a particularly poor fit when applied to HIV counselling. Even in instances when this approach may be appropriate, the lengthy time often required for clients to uncover unconscious material is simply not available in most HIV counselling situations. Individuals may present for HIV testing in a state of heightened anxiety, perhaps even crisis. Time can be a critical factor in HIV counselling, and individuals may need to quickly change their risk-related behaviours. Similarly, HIV-infected clients need to have their emotional support and coping needs promptly addressed. Although a client-centred approach adequately addresses several of the tasks of HIV counselling (relationship building, and providing emotional and coping support), the risk assessment in developing a behaviour change plan demands a more directive counselling approach.

4.1.2. Strengths and weaknesses of HIV Counselling and Testing

Clearly, pre-test counselling, post-test counselling, and follow-up counselling are recognised as a vital part of the IEC-based strategy; this places high priority on providing information, education, and prevention. However, some counselling sessions may turn out to be little more than impersonal information-giving exercises rather than counselling that is growth oriented and therapeutic. This approach also places great pressure on counsellors to be knowledgeable in order to meet clients' demand for information. Authors advise that individuals require a considerable amount of training and/or experience in a broad range of areas if they are to feel comfortable in fulfilling the role of HIV counsellor and live up to the WHO's definition (Miller & Bor, 1988; Green & McCreaner, 1989).

Table 4.1 describes cognitive behavioural interventions for common symptoms experienced by people with HIV/AIDS (Sikkema & Kelly, 1996). Is behaviour therapy more appropriate for

people with HIV/AIDS?

Table 4.1: Cognitive behavioural interventions for common symptoms experienced by people with HIV/AIDS (Sikkema & Kelly, 1996)

Symptoms	cognitive behavioural interventions
a. Nutritional disorders	1. self-monitoring of food intake, 2. graded daily eating assignments; external or self-administered reinforcement contingencies for attaining goals related to eating and maintaining or gaining weight, 3. cognitive-modification strategies to strengthen perceived self-efficacy of efforts to regain or maintain appropriate weight
nausea and vomiting (side effects of cancer chemotherapy)	hypnosis, muscle and imaginal relaxation, biofeedback, systematic desensitisation, and attentional diversion/redirection
b. Pain	cognitive therapies (e.g. distraction, imagery, pain redefinition), relaxation or self-hypnosis, contingency management, problem-solving training, communication skills training, and coping skills training
c. Sleep disorders	stimulus control therapies, sleep restriction therapies, relaxation approaches, paradoxical intention interventions, and sleep education.

Direct responses to the issues described above differ fundamentally from a client-centred approach which does not encourage the directive approach to counselling. Ideally, the risk assessment in pre- and post-testing counselling, emphasised by Sikkema & Bissett (1997), encourages clients to identify, understand, and acknowledge their personal risk of acquiring or transmitting HIV. The goal is to help the client create a cognitive behavioural plan to reduce and eliminate acknowledged risks and to begin to understand and come to terms with the implications of a test result. Then, the counsellor moves into a discussion of the appropriateness of testing and reconfirms with the client if testing is still desired (Sikkema & Bissett, 1997). Clients may need instruction in the development of behavioural skills, such as proper condom use, needle hygiene, or assertiveness in negotiating safer sex practices (Sikkema & Bissett, 1997). However, a weakness of such counselling is that it is often extremely brief, from 2 to 20 minutes in pre-test counselling and 20 to 30 minutes in post-test counselling. It is doubtful how much information a counsellor can impart and how much action can be taken in such a brief counselling encounters. It is extremely doubtful whether clients benefit from such brief intervention.

4.2. The effectiveness of HIV CT aimed at the prevention of HIV transmission

The combination of HIV antibody testing and counselling, both before and after the test, is a key component of the strategy for the prevention of HIV transmission (Rugg *et al,* 1991; Otten *et al,* 1993; Phillips & Coates, 1995; DiScenza *et al,* 1996). However, it is not clear if it is a useful primary prevention strategy (Phillips & Coates, 1995), and the effectiveness of HIV CT in reducing risky behaviour is unclear (Green, 1989; Silverman, 1990; Higgins *et al,* 1991; Porche et al, 1992; Otten *et al,* 1993; Choi & Coates, 1994; Sikkema & Bissett, 1997).

4.2.1. HIV CT for Homosexual or bisexual men

Homosexuals were the first to be diagnosed as having AIDS in the early 1980s (Koch, 1987; Echenberg, 1988). Homosexual and bisexual men in Western industrialised nations have made a dramatic behavioural change in their practice of unprotected sex and multiple sexual partnerships since the first years of the AIDS epidemic (early 1980s)(Carne *et al,* 1987; van Griensven *et al,* 1989). Several studies suggest that much of this change may have occurred prior to the availability of HIV CT before 1985. Therefore, the extent to which HIV CT has an effect on these changes is much less clear (Higgins *et al,* 1991).

All longitudinal studies of homosexual men have reported reductions in risk behaviour among both tested and untested men, and a few have reported greater decreases among seropositive men than among seronegative men and those untested or unaware of their serostatus. Higgins *et al* (1991) indicate that the magnitude of longitudinal change was similar for those aware and those unaware of their antibody status. This suggests that changes in behaviour were independent of knowledge of serostatus and behaviour change was not a result of HIV CT. However, Choi and Coates (1994) suggest that HIV CT is associated with lowering sexual risk behaviour among homosexual men.

Nevertheless, many gay men who initiated risk reduction practices at an early stage in the epidemic, have relapsed to unsafe sex and young homosexual men have emerged as a new generation of the gay population that practiced unsafe sex (Choi & Coates, 1994).

4.2.2. HIV CT for women about pregnancy decisions

As mentioned in Chapter three, most children with AIDS have acquired HIV infection from infected mothers. Little evidence has been found for the impact of HIV CT on pregnancy and/or pregnancy termination rates for either seropositive or seronegative high-risk women (Higgins *et al,* 1991). Thus, HIV CT has not been demonstrated as having an impact on pregnancy decisions among seropositive women (Higgins *et al,* 1991; Choi & Coates, 1994).

4.2.3. HIV CT for discordant couples

As mentioned in Chapter one, the numbers of AIDS cases confirm a steady spread of the disease among heterosexuals. HIV CT with couples has been associated with reductions in HIV transmission among discordant couples[27] (Higgins *et al,* 1991; Allen *et al,* 1992; Choi & Coates, 1994). HIV CT might have greater impact on risk behaviour when provided in a social context (Phillips & Coates, 1995). In Rwanda, Allen *et al* identified 60 HIV discordant couples, and 53 were followed for an average of 2.2 years. Only two of the women and 4 of the men in the 60 discordant couples had ever used condoms before the study. Yet, the proportion of discordant couples using condoms increased to 57% (34 of 60 discordant couples) at one year follow up. During follow up, two of the 23 HIV negative men and six of the 30 HIV negative women seroconverted. They concluded that HIV CT caused a large increase in condom use and was associated with a lower rate of new HIV infections.

4.2.4. HIV CT for adolescents

It has been discussed in Chapter one that HIV infection is growing among teenagers and young adults, and the rate of HIV infection was much higher among female teenagers than among male teenagers. Thus, since many people contract the HIV while they are still teenagers, it is important that teenagers be knowledgable about HIV infection and behaviour in ways to minimise its threat (White *et al,* 1988). However, only one published study has been reported among 15 HIV infected adolescents (6 females and 9 males) (Futterman *et al,* 1990). Ten of the fifteen adolescents had minimal or no pre-test counselling. Futterman *et al* (1990) reported that the majority of males, but none of the females, reported increasing safer sexual practices.

- For females, five had fewer than five partners and 1 had more than fifty partners before their

[27] Discordant couples refers to one sexual partner who is HIV negative and the other partner who is HIV positive (Higgins *et al,* 1991; Allen *et al,* 1992; Choi &Coates, 1994).

HIV status was known; they all continued minimal or no condom use after their HIV positive status was known.

- For males, two had fewer than 20 partners and seven had more than 50 partners before knowing their HIV status. After their HIV positive status was known, 33% were abstinent, 33% increased condom use, and 33% continued high risk sexual activities.

4.2.5. HIV CT for Intravenous drug user

As mention in Chapter three, the greatest number of new infections in 1992 was likely to be in the drug addict population. Higgins *et al* (1991) reported reductions in intravenous drug use and sexual risk behaviours regardless of counselling and testing experience. They found that behaviour changes were not dependent on learning that one was or was not infected with HIV. However, Choi and Coates (1994) suggested that HIV CT was associated with lowering sexual risk behaviour among injecting drug use (IDU).

4.2.6. Post-test counselling for blood donors

In the 1980s, the risk of HIV infection rested on the transfusion of HIV-contaminated blood or blood components. Among blood donors who were HIV positive, notification of HIV infection and post-test counselling appeared to bring about a short-term behavioural change (Cleary *et al,* 1991). The intervention involved mail notification of serostatus and post-test counselling to blood donors who were confirmed HIV-positive (n = 271).[28] When study participants were reinterviewed 2 weeks after the intervention (n = 196), significantly fewer men (from 68% to 40%)(women - 58% to 38%) reported unsafe sex (Cleary *et al,* 1991). However, 40% of the participants still reported having engaged in unsafe activities after receiving post-test counselling. A surprising finding was that many men and women who donated for transfusion were not aware of the risk factors for infection and did not report being subject to a major HIV risk factor.

4.2.7. Post-test counselling for STD patients

People attending sexually transmitted diseases clinics may be considered at increased risk for HIV infection (Fennema *et al,* 1998). Wenger *et al* (1991) reported results from their study in a

[28] During the study period, there were 708 confirmed HIV-antibody-positive donors. Five hundred and thirty-nine donors contacted the Blood Center. Two hundren and seventy-one patients enrolled in the study, representing 50% of the donors who contacted the study team and 38% of detected seropositive donors.

sexually transmitted disease clinic. They found that patients who received a negative HIV test result and post-test counselling were significantly more concerned about acquiring HIV and were more likely to question their sex partners about AIDS than those who did not receive testing and counselling. There were changes in self-reported behaviour over time both in the tested and in the untested groups; 40% of the tested group vs 20% of the untested group used condoms, avoided genital intercourse, or knew their partner had a negative HIV test (Wenger *et al,* 1991).

However, Otten *et al* (1993) discovered contradicting results of patients attending another sexually transmitted disease clinic. They examined the association between HIV antibody testing and post-test counselling, and changes in risk behaviour of patients. They compared the occurrence of gonorrhoea and sexually transmitted diseases before and after HIV testing among patients receiving and not receiving post-test counselling.

Pre-test counselling lasted approximately 5 minutes. Those who accepted HIV testing were given an appointment to return in 2 weeks to receive the test results and post-test counselling. Post-test counselling lasted approximately 45 minutes for persons who were HIV positive and 15 minutes for those who were HIV negative.

The results are shown in Table 4.2. Ideally, HIV counselling would greatly reduce the risk of sexually transmitted disease. Yet, among those who received post-test counselling in this study, HIV CT was associated with a moderate decrease in sexually transmitted disease among patients who tested positive for the virus (29% and 12% decrease), but risk increased for patients who tested negative (106% and 103% increase). The authors suggest a need to improve post-test counselling in this clinic and to access the effects of counselling and testing in other clinics.

An increase in the occurrence of sexually transmitted disease after patients in this clinic received the results of a negative HIV test result is a matter for concern. The authors suggest that receiving a negative result may produce a sense of relief that can lead to false beliefs of immunity and a reinforcement of past risky behaviour.

The effectiveness of counselling may be influenced by the content and the frequency of counselling, and the type of people conducting the counselling. Yet, it is not clear in these studies, for homosexual or bisexual men, women, heterosexual couples, adolescents, intravenous drug users, blood donors, and STD patients, who provided the counselling, what approach was adopted, and how counselling was conducted. The kind of counselling provided, the length and

number of counselling sessions (except for Otten *et al*, 1993) were not known.

Table 4.2: Summary of results (Otten *et al*, 1993)

	HIV test results (No. of patients)	the percentage with gonorrhoea	the percentage with any sexually transmitted disease	reasons for the visit after HIV antibody testing
Patients received post-test counselling	Positive (331)	29% decrease after post-test counselling	12% decrease after post-test counselling	1. obtain the test results and post-test counselling (78%) 2. follow-up visit (15%) 3. new symptoms or contact with a person with a sexually transmitted disease (4%) 4. others (3%)
	Negative (666)	106% increase after post-test counselling	103% increase after post-test counselling	1. post-test counselling (68%) 2. follow-up visit (25%) 3. new symptoms or contact with a person with a sexually transmitted disease (7 %)
Patients received no post-test counselling	Positive (566)	9% increase after testing	19% decrease after testing	N/A
	Negative (3,958)	23% increase after testing	32% increase after testing	N/A

Approximately 25% of the CDC's HIV prevention budget has been devoted to CT (Phillips & Coates, 1995). It was reported that research in the behavioural sciences, particularly research on patient compliance with medical regimens, suggested that few individuals achieve profound and lasting behavioural changes after one information and counselling session (Higgins *et al*, 1991). It is possible that before achieving lasting behavioural change, an individual may go through a relatively lengthy cognitive and behavioural process, including several cycles of attempted change and relapse (Higgins *et al*, 1991).

Thus, it is not surprising that the combination of HIV testing with a single pre-test and a single post-test counselling session does not effect sustained behavioural changes. Rugg *et al* (1991) raise the same issue that there is little theoretical basis for believing that the basic pre-test (lasting 2 to 20 minutes) and post-test (lasting 20 to 30 minutes) counselling intervention alone could achieve behaviour change without other conditions being present.

Therefore, the effectiveness of HIV CT in reducing risk behaviour is unclear (Higgins *et al*, 1991; Otten *et al*, 1993; Choi & Coates, 1994). HIV CT may have a place in HIV risk reduction, but on its own is not sufficient for HIV risk reduction (Choi & Coates, 1994).

Furthermore, the deployment of a preventive vaccine for HIV will not decrease the need for effective counselling interventions (Grinstead, 1995). Effective counselling interventions must be offered to those who enrol in clinical trials of HIV preventive vaccines. When a vaccine is licensed and distributed, it is unlikely to be 100% effective; even vaccinated individuals must continue to avoid behaviours that could transmit HIV.

4.3. Effectiveness of counselling provision in medical settings

The provision of counselling within general practices has become widespread in recent years (Sibbald *et al*, 1993). However, research into the effectiveness of counselling in primary care is rare and uncertain (Baker *et al*, 1998).

This section carefully evaluates three recent studies, which were carried out in the UK, in relation to the provision of counselling in general practices - Sibbald *et al* (1993), Friedli *et al* (1997), Harvey *et al* (1998) (see summary Table 4.3). Sibbald *et al*'s (1993) study is chosen for discussion because it is a large scale research project among 1,880 general practitioners. Studies by Friedli *et al* (1997) and Harvey *et al* (1998) are chosen for discussion because they both concentrate on the comparison between the effectiveness of counselling and GP care.

- Sibbald *et al* (1993) attempt to establish the prevalence of counselling services in general practice and factors associated with their distribution. They also attempt to describe GPs' perception of the qualifications of counsellors, working arrangements, and referrals of clients.
- Friedli *et al* (1997) attempt to compare the efficacy of and patients' satisfaction with general-practice-based psychotherapists with those of general practitioners in providing treatment to people with emotional difficulties.
- Harvey *et al* (1998) attempt to determine the relative effectiveness and cost-effectiveness of generic counselling and usual general practitioner care for patients with minor mental health problems.

The discussion will be divided into four categories:

1. the definition of counselling in medical settings,
2. brief psychotherapy in general practitioner care,
3. the quality of counselling provision in medical settings, and
4. referrals of clients.

Table 4.3: Summary of studies carried out on the comparison between counselling and general-practice care

Studies	Sibbald *et al* (1993)	Friedli *et al* (1997)	Harvey *et al* (1998)
Settings	general practice in England and Wales	14 general practices in north-west London	9 general practices (5 in Cardiff and 4 in Swansea)
Methods	Postal questionnaire Telephone interview survey	Compare GP care with brief psychotherapy	Compare GP care with brief counselling
Subjects	1880 GPs, 1542 (82%) completed questionnaires	136 patients with emotional difficulties, mainly depression, 18 year-old or over	162 patients with diverse minor mental health problems, 16 year-old and over
a) Intervention group	N/A	70 were randomly assigned to the therapist (also able to see their GP) 59 assessed at 3 months 62 assessed at 9 months	111 were randomly assigned to the counsellor (also allowed to see their GP)
b) Control group	N/A	66 were randomly assigned to the routine GP care 51 assessed at 3 months 55 assessed at 9 months	51 were randomly assigned to the usual GP care
Types of counselling used	586 counsellors were reported by GP providing non-directive counselling	4 counsellors provided brief, non-directive, person-centred psychotherapy	9 counsellors provided brief, person-centred psychotherapy
Lengths of counselling	N/A	50-minute therapy once a week - between 1 and 12 sessions over 12 weeks	up to six 50-minute weekly sessions
Results	586 counsellors were distributed among 484 of the 1,542 practices. 1) 187 community psychiatric nurses; 2) 145 "practice counsellors"; 3) 95 clinical psychologists.	1) All patients improved significantly over time; with no significant differences between the 2 groups. 2) Patients assigned brief psychotherapy were more satisfied with the help they received than those assigned to the GP.	1)there were significant improvements in both groups between randomisation and follow-up for most outcome measures. 2) no clear cost advantage was associated with either intervention.
Training in counselling	1) 197 counsellors had training in counselling 106 were accredited by the BAC 91 were trained by Relate or had completed a counselling or psychotherapy course 2) 85 counsellors' qualification were unknown to the GP. 3) 145 had had no training in counselling	All therapists had the necessary qualifications and experience to be accredited by the BAC.	All counsellors worked part-time and had been in post for at least 4 months before the trial commenced. Counsellors were either BAC accredited or trained to diploma level.
Types of training	N/A	N/A	N/A

4.3.1. The definition of counselling in medical settings

There is an assumption in medical settings that practitioners should concentrate on Rogers' non-directive counselling (Pringle & Laverty, 1993; Sibbald *et al*, 1993; Friedli *et al*, 1997; Harvey *et al*, 1998). Both Friedli *et al* and Harvey *et al* study the efficacy of counselling or psychotherapy that is primarily non-directive, or client-centred.

The role of the counsellor in primary care is potentially very diverse as many health professionals are providing counselling themselves. Thus, counsellors in medical settings need to clarify their responsibilities and duties (Ball & Corney, 1993:99). Friedli *et al* and Harvey *et al* selected professional trained counsellors who predominately favoured non-directive counselling and were not health care professionals.

Although Sibbald *et al* describe the provision of counselling as a *"distinct"* or *"separate"* activity within general practice, the counselling approach is not specified in their definition. The counsellor is defined as: "someone who offers (formal) sessions to patients in which patients are helped to define their problems and enabled to reach their own solutions..." (Sibbald et al, 1993:30). This definition of counselling appears to be more favourable towards the humanistic approach in which emphasis is generally placed on helping clients achieve self-actualisation and on counsellors adopting a non-directive stance.

Two major issues are pointed out in Chapter two that:

a) client-centred counselling or psychotherapy is only one form of counselling among the various approaches to counselling and therapy; and
b) finding scientific evidence for the effectiveness of a humanistic approach to counselling and therapy is neither easy nor straightforward.

Thus, it is not surprising to discover that such counselling practice has no obvious effect on the outcomes of the clients - no significant difference was found between patients offered access to counselling and those given usual care by their GP under randomised, controlled trials (Friedli *et al*, 1997; Harvey *et al*, 1998). Without a no-treatment group, it is not known whether patients in both groups might have improved spontaneously (Friedli *et al*, 1997).

4.3.2. Brief psychotherapy in general practitioner care

Brief psychotherapies have had a great increase in popularity with general practitioners (Friedli *et al*, 1997; Harvey *et al*, 1998). Friedli *et al* (1997) and Harvey *et al* (1998) compared general practitioner care with brief counselling or psychotherapy for patients with emotional difficulties or with diverse minor mental health problems (Table 4.3). One group of patients were assigned to routine GP care and another group of patients were assigned to the therapist or counsellor. Friedli *et al* (1997) and Harvey *et al* (1998) concluded that no differences could be found in patients' mental health outcomes between the groups receiving brief psychotherapy and routine GP care. They suggested that brief, non-directive counselling or psychotherapy was not more effective than usual GP care. Two issues are raised from these conclusions.

First, would other approaches to counselling and therapy be more effective and appropriate in this context? It is not known whether counsellors in these two studies were trained primarily in the humanistic approach. If this is the case, does this suggest that counsellors who practise brief non-directive psychotherapy alone in general practice should be thinking about re-training to other models of therapy which might be more effective for patients in general practice? Or should they refer their clients to other therapists who practice other approaches?

Second, the conclusion that psychotherapy was not more effective than usual GP care, based on the results that no differences could be found between the two groups, appears to be made prematurely. Evidence suggested that some long-term benefits were found among children who received psychotherapy, even though there might be no immediate change in behaviour (Wright *et al*, 1976). Therefore, it is possible that patients who received psychotherapy might have improved by the time they are followed up. As no follow-ups have been reported on the subjects in Friedli *et al* (1997) and Harvey *et al*'s (1998) studies, the long-term effects of psychotherapy among those subjects are unknown.

Friedli *et al* also conclude that patients with emotional difficulties prefer brief psychotherapy to GP care. Brief counselling, or psychotherapy, usually refers to the number of sessions offered rather than the length of time per session (Day *et al*, 1993; Lai *et al*, 1998). It often remains a standard 50 minutes (Friedli *et al*, 1997; Harvey *et al*, 1998). Yet, Friedli *et al* (1997) and Harvey *et al* (1998) did not specify precisely how much time the GP had per consultation. Their description of "routine general practitioner care" suggests that the GPs probably spent around a

fifth less time per patient than did the counsellors or therapists (Lai *et al*, 1998). This is probably why patient satisfaction was greater for the brief psychotherapy than for those seeing their GPs (Lai *et al*, 1998). If GPs spent 50-minute per session with their patients, would patients be more satisfied with GP care?

Friedli *et al* (1997) and Harvey *et al* (1998) give a detailed description of the provision of brief counselling or psychotherapy, yet, they do not describe the care given in the GP care group. The patients selected in Friedli *et al*'s study had emotional difficulties, mainly depression, and in Harvey *et al*'s study had diverse mental health problems (excluding phobic conditions and psychoses). There is no information about how many patients in each group were taking medication.

4.3.3. The quality of counselling provision in medical settings

Counselling services are widespread in general practice (Sibbald *et al*, 1993). However, counselling in primary care settings remains largely unevaluated (Harvey, 1998). Such evaluation has been of great difficulty as:

- counsellors vary greatly in their training and therapeutic approach;
- clients range from mildly disturbed to severe psychiatric mobidity; and
- much confusion surrounds the training, accreditation, and supervision of counsellors.

General observations concerning the weaknesses of these studies are:

- the number of counsellors providing counselling has been small (4 counsellors in Friedli *et al*'s study and 9 counsellors in Harvey *et al*'s study);
- the counselling sessions provided have been too varied (between 1 and 12 sessions in Friedli *et al*'s study) or not known (in Sibbald *et al* and Harvey *et al*'s studies);
- information about counsellors' supervision is unknown.

General practitioners in Sibbald *et al*'s (1993) study were unaware of what counselling qualifications were held by a fifth of the people who provided this service within their practices. It is surprising that so many general practitioners were prepared to delegate patient care to people whose qualifications were unknown to them. Sibbald *et al* (1993) suggest that this is because there is no accepted accreditation scheme for counsellors, and their training, practice, and

supervision vary greatly. Therefore, according to Sibbald *et al*, in selecting a counsellor, general practitioners may rely more on their personal knowledge of the therapist than on formal qualifications. This highlights the need for regulation in the appointment of counsellors (Yeldham, 1993).

One hundred and forty-five of the 342 counsellors in Sibbald *et al*'s study, whose qualifications were known to the general practitioner, had had no training in counselling. Sibbald *et al* suggest that this is unimportant if training has no effect on the quality of care or outcomes for patients. Similarly, Corney (1993) also suggests that whether training improves outcomes is doubtful and there is often a greater variance in outcomes for treated clients than for untreated controls. Corney suggests that some clients may be harmed by counselling intervention. Evaluative trials should aim to identify those patients who may be harmed (Corney, 1993). It is important to know the level of skills that is necessary for benefit to occur (Corney, 1993). How much training and what level of expertise is necessary for benefit to occur?

It is argued in Chapter Two that the essence of non-directive therapy is the relationship between the therapist and the client. Perhaps the most threatening implication of the relationship as the core of therapy is that psychotherapy is not perceived as a profession (Patterson, 1980). Many of the requirements of professional counselling training are then unnecessary or irrelevant to providing a therapeutic relationship. In this case, it is not surprising that 145 of the 342 counsellors employed in general practice had had no training in counselling (Sibbald *et al*, 1993).

4.3.4. Referrals of clients

In order to focus on counsellors who have no other jobs within the practice, Sibbald *et al* (1993) define counselling as a distinct or separate activity. By doing this they have excluded some medical professionals who also provide counselling. However, there is a major weakness in this study. It has been discussed before that Sibbald *et al* (1993) define counselling as non-directive, that is, within the domain of the humanistic approaches. The disadvantage of such a definition is that it excludes other approaches to counselling and is obviously not sufficient when encountering clients' problems such as those described in the following referrals.

General practitioners were asked by Sibbald *et al* (1993) which problems of their patients they

referred to the counsellor. Although they reported that the full range of patient problems was reported to each type of counsellor, the balance of problems differed among them. The results are as follows which suggest that GPs were able to distinguish between the problems the refered to the counsellor.

- Community psychiatric nurses were more likely to be referred patients with anxiety or depression, personality disorder, or psychotic illness. This suggests that general practitioners see these nurses as skilled in the management of psychiatric illness.
- Practice counsellors were more likely to be referred bereaved patients. This suggests that general practitioners perceive bereavement as a problem which responds better to the intervention of practice counsellors.
- Clinical psychologists were more likely to be referred patients with psychosexual problems, eating disorders, phobias, or obsessive-compulsive disorders. This suggests the view of general practitioners that behavioural therapies are practised by these psychologists.

Initially, these three types of counsellors - community psychiatric nurses, practice counsellors, and clinical psychologists - were described by general practitioners as having fulfilled Sibbald *et al*'s definition of the role of counsellor. The counsellor is: "someone who offers (formal) sessions to patients in which patients are helped to define their problems and enabled to reach their own solutions..." (Sibbald *et al*, 1993:30). This implies a non-directive approach.

It would be interesting to find out the level of effectiveness of these counsellors who, reported by the general practitioners, have practised non-directive counselling on their referred clients with problems of anxiety, depression, personality disorder, psychotic illness, bereavement, psychosexual problems, eating disorders, phobias, or obsessive-compulsive disorders. It is extremely doubtful whether patients with such problems "are helped to define their problems and enabled to reach their own solutions..." (Sibbald *et al*, 1993:30), if offered non-directive counselling.

4.4. Counselling expertise in care workers who provide counselling to people with HIV/AIDS

As discussed in Chapter one, during the course of HIV infection, a broad range of physical needs and problems are likely to be experienced. These are not constant, but will progressively become more serious and difficult to handle. The changing nature of these needs imposes a variety of psychological and emotional strains on infected individuals and those closest to them. These strains may make the infected person feel that he or she is losing identity, independence, privacy, and social status. They can also provoke guilt, anger, and fear of loneliness in the face of dying and death. Much of the stress experienced by people infected with HIV may reflect underlying anxieties about economic independence and family obligations. Dealing with HIV infection also imposes direct and indirect financial costs, which can be particularly stressful if economic productivity is affected by illness.

4.4.1. The perceptions of health professionals for working with people with HIV/AIDS

People with HIV/AIDS have generally been treated in hospitals. Yet, many patients have been reluctant to consult their general practitioners (Saunders, 1994). The reasons for this, according to Saunders (1994), are the patients' fear of hostility and rejection, lack of confidentiality, and lack of knowledge about health professionals. On the other hand, health professionals have similar fears and anxieties about HIV and AIDS; and also feel insecure with a disease that is new and ever changing (Klimes *et al*, 1989; Brown-Peterside *et al*, 1991; Carroll, 1991; Saunders, 1994).

Statements have been widely circulated that HIV is very fragile and cannot survive except at body temperature for more than a few minutes and cannot withstand drying (Dixon, 1990). However, according to Dixon (1990), these statements were obviously wrong. Dixon (1990) described how researchers took samples of HIV and placed them on a number of dishes to dry. After a day, the first sample was tested to see if it was infectious, and it was. The second day's sample was also infectious, and so on, right up to the end of a week. Some of the virus survived in dry dust for up to seven days. Then they repeated the experiment using the virus in water. They took samples each day and found that even after two whole weeks in water a few virus particles

remained capable of causing infection. The public had been told that pasteurisation (fifty-six degrees centigrade for twenty minutes) killed the virus. However, this same research showed that heating to fifty-six degrees centigrade must be continued for at least three hours to destroy all virus particles.

According to Dixon (1990), although this study was included in Great Britain's Department of Health circular on preventing cross-infection, it has not been widely reported. Sixty thousand copies were distributed to all the health districts in the UK, yet hardly anyone has seen it. Dixon (1990) thinks the reason is that medical personnel are scared that if everyone knew about it they would be even more reluctant to look after those with AIDS.

Klimes *et al* (1989) surveyed 400 nurses' and doctors' (256/400, 64% returned the questionnaire) attitudes to care for HIV patients. One quarter of the sample (24%) expressed anxiety about becoming infected by HIV, in spite of taking precautions. One third (30%) thought that they should have the right to refuse to care for HIV positive patients. Examination of differences in attitude amongst professional groups showed that in contrast to general and psychiatric nurses, both hospital doctors and community nurses had significantly more favourable attitudes to the integrated clinical management of HIV patients and that they were also least afraid of being infected. Community nurses had a significantly more favourable attitude towards patients from different transmission groups, and were also on the whole most positive regarding close social contact with HIV infected people. The majority (88%) were not worried about working closely with a colleague with HIV infection.

Three important issues are raised:

- the need for more knowledge about AIDS among health professionals;
- health professionals' confidence in the discussion of the implication of HIV infection and AIDS; and
- health professionals' experience in caring for HIV positive patients and their attitudes towards patients.

a) The need for more knowledge about AIDS

The need for more extensive AIDS education for health care professionals has frequently been noted (Klimes *et al*, 1989; Brown-Peterside *et al*, 1991; Carroll, 1991; Saunders, 1994) since

they (the health professionals) often provide information and have fears (essentially unfounded) for their own safety in terms of HIV infection. Klimes *et al* (1989) suggest that the need for more knowledge about AIDS among health professionals is high as shown in Table 4.4 below. The majority of them urge the need for more knowledge about AIDS.

Table 4.4: The need for more knowledge about AIDS reported by health professionals (Klimes *et al,* 1989)

Occupation	No of sample (%)
Psychiatric nurse	100 (87%)
General hospital nurse	100 (84%)
Community nurse	100 (72%)
Hospital doctor	100 (53%)

Carroll (1991) in the United States and Brown-Peterside *et al* (1991) in the UK have both noted the need for more extensive AIDS education for health care professionals, since they have been found to hold negative and fearful attitudes towards people with AIDS. They all suggest that these stigmatising attitudes and fears can interfere with their interest, knowledge and ease in dealing with their patients.

Data analysis from Carroll's two studies (1991), exploring AIDS education and teaching methods in late 1989 and 1990, revealed that many medical and nursing students[29] reported that they did not feel comfortable interacting with persons with AIDS, their lovers or family members.

b) Confidence in the discussion of the implication of HIV infection and AIDS

Sherr (1989) reported that AIDS information was not routinely discussed with doctors although they were the most credible source. She reviewed a study on the discussion of AIDS with doctors. Of 2,000 patients, only 15% had talked about AIDS with their doctors; and of those, 72% had been patient initiated (Sherr, 1989).

However, Klimes *et al* (1989) found that over three quarters of the respondents (nurses and doctors) would be comfortable discussing the implications of HIV infection with their patients in a clinical situation. A high proportion of respondents (80%) were prepared to discuss the implications of HIV infection with the patient and his or her partner or relative. They were equally divided in their opinion as regards sharing a house with a carrier of HIV, and only a few

[29] Carroll (1991) studied 89 first year medical students in late 1989 and 34 nursing students in 1990.

(4%) believed that AIDS patients had what they deserved.

In order to access the adequacy of education about HIV and AIDS in vocational training for general practice, Brown-Peterside *et al* (1991) carried out a national survey investigating the knowledge, skills and attitudes of trainers and their trainees. They also found that 99% of trainees felt able to advise patients on the avoidance of HIV infection. However, it was concluded in this survey that there was a need to improve teaching about HIV and AIDS in vocational training for general practice. Brown-Peterside *et al* (1991) suggested that all general practitioner trainees should receive a tutorial to update their knowledge about HIV and AIDS; and should attend a suitable workshop to challenge unfavourable attitudes and improve confidence in counselling.

c) Experience in caring for HIV positive patients and attitudes towards patients

Surprisingly, more than half (298, 55%) of the trainees in Brown-Peterside *et al*'s (1991) national survey had had personal experience of patients with HIV or AIDS and many staff in Klimes *et al*'s (1989) study reported having looked after HIV positive patients (Table 4.5).

Table 4.5: Previous experience in caring for HIV positive patients (Klimes *et al*, 1989)

Staff	No of sample	%
hospital doctors	17	29%
general hospital nurses	24	41%
psychiatric nurses	9	18%
community nurses	6	8%

They found that previous contact with HIV positive patients had an effect on levels of knowledge, but not on attitudes towards patients. This would suggest that strongly held beliefs and attitudes did not change simply by exposure to patients, and that more specific and subtle influences would be required to change attitudes (Klimes *et al*, 1989).

On the other hand, being better informed about HIV tends to be associated with more positive attitudes to patients and their care, and also with appropriate professional behaviour and lower anxiety (Klimes *et al*, 1989). This finding of a positive relationship between degree of knowledge and favourable attitudes underlies the importance of staff training. Klimes *et al* (1989) could not prove a causal relationship between knowledge and attitudes, and not all attitudes changed simply

as a result of being better informed. However, they argued that both knowledge and attitudes combined to influence the quality of care and infection control, and both needed to be addressed in staff training.

4.4.2. Training, competence, and experience of HIV counsellors

This section reviews four studies (Burnard, 1992b; Coyle & Soodin, 1992; Brown-Peterside *et al*, 1991; Bond, 1991) on training, competence, and experience of HIV counsellors (Table 4.6).

Table 4.6: Summary of four studies on training, competence, and experience of HIV counsellors

Studies	Burnard (1992b)	Coyle & Soodin (1992)	Bond (1991)	Brown-Peterside *et al* (1991)
Sample	21 1) 2 AIDS counsellors, 2) 9 nurse/midwife teachers with an interest in AIDS counselling, 3) 2 district AIDS co-ordinators, 4) 2 Gay Switchboard counsellors, 5) 2 counsellor trainers/ facilitators, 6) 2 Practising nurses, 7) 1 Priest working with people with AIDS	90 nurses, health advisers, and HIV/AIDS counsellors in STD clinics and HIV counselling centres. 29 (32.2%) returned	1) Four consultation days for 142 HIV counsellors 2) Consultation day for 38 managers of HIV counsellors 3) 33 HIV counsellors offered diaries 4) 33 out of 83 Family Practitioner Committees giving their views about the use of HIV counselling 5) 13 clients completed questionnaires about their views towards HIV counselling	986 GP trainers, 616 (62%) returned 924 GP trainees, 538 (58%) returned
Regions	N/A	Four Thames Regional Health Authorities	1) Four consultation days for HIV counsellors held at Leeds, Bristol, Birmingham and London. 2) Consultation day for managers of HIV counsellors held in London	West Scotland, south east Scotland, Yorkshire, Mersey, north west Thames, north east Thames and south east Thames.
Method	Semi-structured Interviews face-to-face or telephone Lasted between 35 minutes and 1 1/2 hours	Questionnaire	1) Small group discussion 2) Pre-consultation day questionnaire to HIV counsellors: 219 returned 3) Diaries of HIV counselling offered during Sept. 1990 4) 33 family Practitioner Committees giving their views about the use of HIV counselling 5) Questionnaires to clients about their views towards HIV counselling: 13 replied	Questionnaire

a) Counselling Training

Several authors advise that individuals would require a considerable amount of training and/or experience in a broad range of areas if they are to feel comfortable in fulfilling the role of HIV counsellor within the WHO's definition (Miller & Bor, 1988; Green & McCreaner, 1989).

Ratigan (1997) argues that effective counselling is best undertaken by someone who has completed, or is well on the way towards completing, a thorough training either in counselling, psychotherapy, or counselling psychology. He emphasises three elements of counselling training (theoretical instruction, well-supervised clinical practice, and the experience of personal therapy or counselling) that are necessary before beginning this demanding work for people with HIV/AIDS. In addition, Brammer *et al* (1993) suggest that counselling effectiveness is maximal when counsellors and psychotherapists have two strong and balanced components: technical qualifications and personal relationship skills. However, most care workers who provide counselling to people with HIV/AIDS are not qualified or accredited counsellors.

BAC Accredited Counsellors

The BAC accredited counsellors are highly experienced. To be eligible they have to fulfil one of three conditions (Ball & Corney, 1993:99):

(a) to have completed a BAC recognised training course and have undertaken 450 hours' supervised counselling practice over three years; or

(b) to have undertaken 450 hours' training (250 theory and 200 skills development) in addition to the 450 hours' counselling practice; or

(c) to have had 10 years' experience of counselling (at a minimum of 150 hours per year) including on-going supervision.

At the moment, anybody can offer their services by describing themselves as a counsellor. The BAC operates an accreditation scheme for counsellors and approved persons are eligible to refer to themselves as BAC Accredited Counsellors (Woolfe *et al*, 1993). However, Woolfe *et al* (1993) reviewed a study in 1986 showing that the percentage of BAC members accredited stood at less than 9 percent. Therefore, there is no doubt that a very large number of persons throughout the UK are offering private counselling services and it is extremely unlikely that more than a small proportion of these are accredited by the BAC (Woolfe *et al*, 1993).

While Coyle & Soodin (1992) place strong emphasis on the investigation of both general counselling training and HIV counselling training for HIV counsellors, this is not significant in Brown-Peterside *et al*'s (1991) study (table 4.7). This reflects a failure by those who provide HIV counselling within medical settings (e.g. GPs) to grasp the need for counselling, what counselling actually involves and the ways in which it differs, or should differ, from the giving of information and the dispensing of advice.

Bond (1991) asked for information on the respondents' background of general counselling training but ignored the background of HIV counselling training (Table 4.7). The reason for this is possibly that during the consultations in his study, it was pointed out many times by experienced counsellors that the issues raised by clients in on-going HIV counselling were similar to the concerns of clients in quite different circumstances. It was considered important that HIV counsellors were trained to the same level as other counsellors in generic counselling theory and methods.

Table 4.7: Counselling training

Studies	General counselling training	HIV counselling training	Models of counselling used
Brown-Peterside *et al* (1991)	N/A	N/A	N/A
Bond (1991)	3% received no general counselling training 11% were trained at certificate level or higher	N/A	Person-Centred (28%) Developmental-eclectic (14%) Gestalt (9%) Systemic (7%) Psychodynamic (6%) Bereavement (5%) Cognitive Behavioural (4%)
Coyle & Soodin (1992)	13 person-centred, 4 psychodynamic, 3 behavioural, 2 eclectic. 1 BAC accredited 7 (24%) no training 34% were trained at certificate level or higher	6 had no HIV counselling training	N/A

General counselling training

Thirteen respondents in Coyle & Soodin's study said that their general counselling training had been person-centred, four psychodynamic, three behavioural and two eclectic (Table 4.7). Only one respondent (out of 29) had completed a counselling course that was accredited by the British Association for Counselling. Seven respondents (24%) reported that they had received no general counselling training.

Table 4.8 lists general counselling courses respondents received.

Table 4.8: The frequency of general counselling courses

Description of course	Frequency (n=26)
Short/basic counselling skills course	7 (26.9%)
Counselling diploma	5 (19.2%)
Certificate of counselling	4 (15.4%)
Introductory counselling course	3 (11.5%)
Course on bereavement counselling	3 (11.5%)
Course on counselling in sexual problems	3 (11.5%)
Telephone counselling course	1 (3.8%)

Source: Coyle & Soodin, 1992:219

There is a lack of training among counsellors offering HIV/AIDS counselling in Bond's study. The training background of counsellors is described in Table 4.9 below.

Table 4.9: Training background of the counsellors

Training background of the counsellors	numbers of the counsellors
had in-house training,	49 (22%)
were trained in counselling skills	43 (20%)
relied on the professional training as a social worker, nurse, etc.	40 (18%)
had attended the National AIDS Counselling Training Unit (NACTU)	28 (13%)
had advanced training in counselling and psychotherapy	24 (11%)
ENB specialist training for nurses	17 (8%)
had attended the Terrence Higgins Trust or other voluntary organisation training	9 (4%)
have no training for counselling	6 (3%)
had attended Cruse bereavement training	3 (1%)
Total	219 (100%)

Source: Adopted from Bond, 1991:88

Bond suggests that these figures need to be treated cautiously because of the brevity of the answers. Yet, they do appear to reveal a general lack of training in counselling in this new area of work. Coyle & Soodin reported that 34% of HIV counsellors in their study were trained to certificate level or higher. However, only 11% of HIV counsellors in Bond's report were reported as having received training to a comparable level despite their demanding role. They suggested that much more extensive training in counselling is required for HIV/AIDS counsellors. However, no studies suggest that trained counsellors are more effective than untrained counsellors.

Training for HIV counselling

The most notable findings to emerge from Coyle & Soodin's study were as follows.

- Six respondents, who were responsible for providing HIV counselling in their workplace, reported that they had not received any formal training in HIV counselling.
- The training, undertaken by the other respondents, was generally of relatively short duration. These varied in duration from courses lasting for one day to those lasting for one year (Table 4.10).

These raised difficulties for some respondents when dealing with 'dreaded issues', such as death and bereavement (Coyle & Soodin, 1992). Sherr *et al* suggest that the range and intensity of emotions of people with HIV/AIDS may challenge counsellors. They need to be equipped to help clients with overwhelming levels of depression and guilt (Sherr *et al*, 1992).

Table 4.10: Duration of training for HIV counselling (Coyle & Soodin, 1992)

HIV counselling courses duration	No. of respondents
One day	2
Two to three days	7
One to two weeks	8
One year	2
No training received	6
Total	25

Models of counselling used

Only Bond addresses the models of counselling used by counsellors working with people with HIV/AIDS. Rogers' person-centred counselling was used most in Bond's national survey of HIV counsellors (Bond, 1991). Eighty-two HIV counsellors in Bond's report (1991) replied to a question asking them to indicate any model of counselling that they had found particularly useful, mentioning the name of its founder or a well-known practitioner wherever possible, to enable the researchers to study it further. They reported a total of 152 separate responses. The results demonstrated that many listed more than one model which suggests that those counsellors tended to be eclectic in their counselling approach. The results are shown in the table below.[30]

[30] A total of thirty-four different models were mentioned. Those not included in the table were listed by four or fewer respondents. (Bond, 1991)

Table 4.11: Models of counselling used

Counselling model	Number of responses (% of 152)
Person-Centred (Rogers)	43 (28)
Developmental-eclectic (Egan)	22 (14)
Gestalt (Perls)	14 (9)
Systemic Therapy (Miller, Bor)	10 (7)
Psychodynamic	9 (6)
Bereavement (Kubler-Ross, Stedeford)	7 (5)
Cognitive Behavioural	6 (4)

Source: adapted from Bond, 1991:77

According to Bond, there is no evidence to suggest that any particular approach is more effective than any other. However, the table above shows a preference for Rogers' "person-centred" counselling which is used most by the respondents even though the percentage is still low (28%). This result gives no idea of the effectiveness of counselling and Bond does not discuss why this approach is preferred by HIV counsellors.

It is noted in Chapter two that Rogers believed that a truly therapeutic relationship between client and counsellor depended on the existence, within the counsellor, of three 'core' conditions which he referred to as congruence, unconditional positive regard, and empathy. Rogers claimed that these conditions were not just important or useful, but sufficient in themselves. The view that no other therapeutic ingredients were necessary invited a confrontation with psychoanalysts, for example, who would regard interpretation as necessary, or behaviourists, who would see techniques for inducing behaviour change as central.

Moreover, Patterson raises three issues which challenge Rogers' ideas (Patterson, 1980:665). First, the idea that the essence of psychotherapy is the relationship between the therapist and the client appears to be too simple. For Patterson, it is difficult to accept the fact that the relationship can have such profound effects on so many different problems and so many different kinds of clients. He emphasises the idea of different techniques for different problems and for different clients appears to be more logical. Second, Patterson suggests that the concept that the relationship is the essence of psychotherapy is threatening because it places responsibility solely on the therapist. Third, Patterson disagrees with the implication of the relationship as the core of psychotherapy, and by doing this psychotherapy is not perceived as a profession. Therefore, it does not require a degree, neither a Ph.D., M.A., Diploma, nor a B.A., many of the requirements of which are unnecessary or irrelevant to providing a therapeutic relationship (Patterson, 1980:665).

Training for AIDS counselling

Burnard (1992b) reported that few of the respondents felt that all nurses need to take formal training as AIDS counsellors, but almost all expressed the view that all nurses should have a knowledge and understanding of HIV/AIDS. Many of the respondents thought that nurses who worked directly with people with AIDS should train as counsellors, and some respondents thought it appropriate for psychiatric nurses to take such training (Table 4.12).

Table 4.12: Nurses and AIDS counselling

View expressed	Numbers of respondents expressing the view (n = 21)
All nurses should have knowledge and understanding of AIDS and HIV	20
Not all nurses need to train as AIDS counsellors	19
AIDS should be discussed early in nurse training	19
Nurses who work with people with AIDS should also train as AIDS counsellors	13
Psychiatric nurses could train as AIDS counsellors	5
Community nurses could train as AIDS counsellors	2

Source: Adapted from Burnard, 1992b:37

AIDS counselling course

According to Burnard (1992b), although there was considerable disagreement about the ideal length of a counselling course for nurses, with suggestions ranging from one or two-day workshops to 2-year diploma courses, most of the respondents felt that up-to-date information about AIDS was the priority in a counselling course, followed by the teaching of a range of basic counselling skills. Such skills were identified as including simple questioning techniques, and reflection and empathy development.

The AIDS counsellors in the sample were particularly firm that the ability to empathise was a necessary quality of the AIDS counsellor. A number of respondents felt that AIDS counselling courses for nurses should involve the discussion of sexuality both from the point of view of information about different sorts of sexuality and from the point of view of nurses exploring their own sexuality. Linked to this was the notion of self-awareness, and many respondents felt that counsellors had to have sorted out their feelings about their own sexuality and dying if they were to be effective counsellors.

Burnard (1992b) concludes that counselling is a necessary part of the support service offered to people with HIV/AIDS, but is not necessarily a task suitable for nurses.

b) Competence

Among these three studies, Brown-Peterside *et al* focused on the respondents' confidence in offering counselling to people with HIV/AIDS (Table 4.13).

Table 4.13: Perception of respondents' competence in offering counselling to people with HIV/AIDS

Studies	Competence
Brown-Peterside *et al* (1991)	1. fewer trainees than trainers were confident in offering HIV/AIDS counselling (37% vs. 63%) 2. lacked confidence in offering counselling because of lack of experience (93% vs. 90%), lack of knowledge (39% vs. 38%), and lack of skill (2%). 3. older trainees (aged 30 years or more) were more confident than younger trainees (50% vs. 36%). 4. confidence was significantly higher among those who had found lectures a useful source of information about HIV and AIDS (45% vs. 31%). 5. trainers were significantly more confident than trainees in counselling the 'worried well' (96% vs. 88%), patients wanting an HIV test (94% vs. 70%), and patients found to be HIV positive (68% vs. 40%). 6. For both trainers and trainees, counselling patients found to be HIV positive proved the most difficult.
Bond (1991)	N/A
Coyle & Soodin (1992)	12 feel ill-prepared for HIV counselling

Brown-Peterside *et al* (1991) found that significantly fewer trainees than trainers were confident in their ability to offer counselling on HIV and AIDS (37% vs. 63%). This suggests their inadequacy in offering HIV/AIDS counselling - only 37% of trainees felt able to offer counselling about HIV/AIDS. Among those who lacked confidence in offering counselling, the reasons given were mostly lack of experience, lack of knowledge, and lastly, lack of skill (Table 4.14).

Table 4.14: Reasons for lack of confidence in counselling (Brown-Peterside *et al*, 1991)

Reasons	Trainees	Trainers
lack of experience	93%	90%
lack of knowledge	39%	38%
lack of skill	2%	2%

Brown-Peterside *et al* (1991) discovered that trainees' region, sex, their year of qualification, and the months they had completed in a training practice were not significantly associated with counselling skill. Yet, older trainees (aged 30 years or more) were more confident in their ability to counsel than were younger trainees (50% vs. 36%). Confidence was significantly higher among those who had found lectures a useful source of information about HIV and AIDS (45% vs 31%).

Brown-Peterside *et al* (1991) also pointed out that trainers were significantly more confident than trainees in counselling the 'worried well', patients wanting an HIV test, and patients found to be HIV positive. For both trainers and trainees, counselling patients found to be HIV positive proved the most difficult (Table 4.15).

Table 4.15: Aspects of counselling in which trainees and trainers express confidence (Brown-Peterside *et al,* 1991)

Aspects of counselling	Trainees	Trainers
'worried well'	88%	96%
patients wanting an HIV test	70%	94%
patients found to be HIV positive	40%	68%

They suggested that all general practitioner trainees should receive a tutorial to update their knowledge about HIV and AIDS, and attend a suitable workshop to challenge unfavourable attitudes and improve confidence in counselling.

Coyle & Soodin discovered that first, the subjects which respondents felt ill-equipped in addressing, were not HIV counselling in particular, but issues that might be encountered in any counselling interaction. Some counsellors would be able to address these problematic topics at least to some extent by drawing upon skills acquired on general counselling courses and in their fulfilment of quasi-counselling roles in other domains. However, the degree to which this would be sufficient to give counsellors a feeling of confidence in their practice is debatable, particularly when one bears in mind that twelve respondents out of 90 (13%) stated that they felt ill-prepared for their HIV counselling role.

It is therefore recommended by Coyle & Soodin (1992) that those who are accorded responsibility for HIV counselling should have adequate training and/or experience in general counselling, and that HIV counselling courses should be expanded to include a range of issues not directly related to HIV/AIDS, such as relationship problems, suicide, death, dying and bereavement.

Second, individuals are sometimes sent on short HIV counselling courses and are then deemed by their employers to have been adequately trained to fulfil the role of HIV counsellor, regardless of how prepared the individual feels he or she is for that role. Findings suggest that the longer and presumably more in-depth are the courses on general counselling and HIV counselling that an individual attends, the less likely it is that the person will find post-test counselling stressful.

(Coyle & Soodin, 1992)

Other factors that contributed to counsellors feeling ill-prepared to deal with issues raised in HIV counselling were (Coyle & Soodin, 1992):

- a lack of support,
- the need to fulfil multiple roles at work, and
- unclear counselling guidelines.

The last mentioned may be an indicator of inadequate training or of insufficiently clear organisational policies.

c) Counselling experience

Bond's study emphasised the counsellors' actual experience when offering HIV/AIDS counselling. Brown-Peterside *et al* conducted no investigation into the actual counselling experience of the respondents. Coyle & Soodin did not examine the length of respondents' counselling experience but focused on the nature of supervision received.

Table 4.16: Counselling experience

Studies	Counselling experience		
	Counsellors experience	Method of contact	Supervision
Brown-Peterside *et al* (1991)	N/A	N/A	N/A
Bond (1991)	72% (102/142) had experience offering HIV counselling. They had an average of 9.8 years' experience of generic counselling. Over half (54%, 55/102) had over 4 years' experience of HIV counselling.	Most (93%, 186) offered face-to-face counselling. 7% (15) only offered telephone counselling. 77% (154) offered a combination of face-to-face and telephone counselling. 42% (84) also offered group work.	153 (70%) agencies provided some form of supervision of their counsellors. 65 (30%) also provided supervision of workers in other agencies.
Coyle & Soodin (1992)	N/A	N/A	14 received formal supervision 6 received informal supervision 9 received no supervision

Years of counselling experience

72% (102/142) in Bond's study had experience in offering HIV counselling. The others were either new in the post, or working in agencies considering offering HIV counselling. Most of those with experience of offering HIV counselling were well experienced. They had an average of 9.8 years' experience of generic counselling. Over half (54%, 55/102) had over 4 years' experience of HIV counselling.

Method of contact

Most (186, 93%) offered face-to-face counselling. Fifteen (7%) only offered telephone counselling, 154 (77%) offered a combination of face-to-face and telephone counselling, 84 (42%) also offered group work (Bond, 1991).

Counselling session

Coyle & Soodin suggest that counselling sessions for pre- and post-test positive or negative results most commonly lasted between half an hour and an hour. Respondents were on average engaging in over 14 counselling sessions per week.

Supervision

Perhaps more than any other client group, people with HIV/AIDS will challenge counsellors with issues that can be disturbing and upsetting. They can challenge the counsellors to look closely at their own fears and feelings in relation to sex and sexuality, disease, disability, disfigurement, and death and dying (Kiemle, 1994). This emphasises the need for supervision.

Coyle & Soodin found that not only did some counsellors not receive any supervision, but six received only informal supervision. Fourteen respondents reported that they received formal supervision. Of these 20 counsellors who received supervision, half had had their supervision arranged for them by their employers but the other half had to make their own supervisory arrangements.

Table 4.17: Supervision received
(Coyle & Soodin, 1992)

Supervision received	No. of respondents
Formal supervision	14
Informal supervision	6
No supervision	9
Total	29

Coyle & Soodin suggest that this reflects a failure by those in authority within organisations or within centres which provide HIV counselling to grasp what counselling actually involves and the ways in which it differs, or should differ, from the giving of information and the dispensing of advice. Coyle & Soodin conclude that there is a need to review both:

- the training that is given to people whose work involves HIV counselling and
- the criteria that HIV testing centres apply when appointing HIV counsellors.

The aims of such an undertaking might be to establish basic criteria for training and/or experience that must be met by **would-be** HIV counsellors and to reform or standardise training courses so that they are based on well defined counselling principles and approaches.

Bond's survey confirmed the need for more systematic and thorough training and supervision for HIV counsellors. Bond (1991) raises the issue that receiving counselling supervision and support has become widely accepted as essential to counselling practice and is an ethical requirement of all practitioner members of the British Association for Counselling. Bond reported that 153 (70%) agencies provided some form of supervision of their counsellors, 65 (30%) also provided supervision of workers in other agencies.

Given the counsellors' increasing involvement in the care of people with HIV/AIDS, they are involved in more extended contacts with patients. Therefore, Bond (1998) suggests that counsellors are faced with the same extension of skills and personal challenges that working with people with HIV/AIDS inevitably involves. However, it is not sensible to assume that all counsellors will feel competent to take on this role. Counsellors are not generally trained in the conveying of information about HIV/AIDS and its implications that may be requested by patients. Thus, counsellors can learn much from the best practice of health professionals. Bond (1998) states that HIV/AIDS counselling may be better provided by a nurse, doctor, or someone who is already trained and experienced, and employed by the practice for this purpose. However, the level of skills amongst those who specialise in HIV counselling in hospitals and voluntary organisations has proved surprisingly low (Bond, 1991; Coyle & Soodin, 1992; Brown-Peterside *et al*, 1991). When counselling is becoming more available, a close co-operation between counsellors and other members of health care teams, as well as other services provided by social workers and voluntary organisations, will be necessary.

Conclusions

There is a lack of rigorous follow-up study on behaviour change among people with HIV/AIDS. Therefore, the long-term effects of psychotherapy among those subjects are unknown. Evidence suggests that although there might be no immediate change in behaviour after counselling or psychotherapy, long-term benefits were found among children who received such treatment. Therefore, it is possible that patients who received counselling or psychotherapy may have

improved by the time they are followed up.

Moreover, no evidence has demonstrated the benefit of counselling. There was considerable variation in the training of individuals conducting the counselling. HIV counselling can be carried out by unskilled counsellors (3% counsellors had no training in Bond's study, 1991; and 24% in Coyle & Soodin's study, 1992) to highly skilled counsellors (11% in Bond's study, 1991, and 34% in Coyle & Soodin's study, 1992, had certificate level or higher).

The effectiveness of counselling may be influenced by the content and the frequency of counselling, and the type of people conducting the counselling. Yet, it is not clear in these studies, for homosexual or bisexual men, women, heterosexual couples, adolescents, intravenous drug users, blood donors, and STD patients, who provided the counselling, what approach was adopted, and how counselling was conducted. The kind of counselling provided, and the length and number of counselling sessions were not known. How much counselling training and what level of expertise is necessary for benefit for clients to occur?

Furthermore, there appears to be no published study that has compared whether experienced counsellors are better prepared than trainee counsellors to cope with the problems posed by HIV and AIDS despite the fact that counsellors have an important part to play in restraining the spread of AIDS. Therefore, it is necessary to investigate the perceptions of experienced and trainee counsellors.

It has been suggested that counsellors trained in the 1990s will be working directly or indirectly with AIDS-related issues, regardless of their work settings (House *et al*, 1995). The literature review is used as a framework for the research questions. The research question for the preliminary study is: "in actual practice, is counselling a central response to women with HIV/AIDS?" The research question for the main study is "how do counsellors perceive their role in working with people with HIV/AIDS?"

Part three explores the methodology for the preliminary study. The preliminary study is carried out among individuals who were responsible for HIV counselling in STD clinics and HIV counselling centres (Coyle and Soodin, 1992). Those to whom the questionnaire was sent fulfilled a variety of occupational roles, the most common ones being 'nurse', 'health adviser' and 'HIV/AIDS counsellor' (Coyle and Soodin, 1992). Part four, the main field work of this research is then carried out among experienced counsellors and trainee counsellors.

Part Three:

Preliminary Study

CHAPTER FIVE: Rationale for the Preliminary Study

Introduction

This section starts with the rationale for the preliminary study among counsellors working for clients with HIV/AIDS, with special reference to women with HIV/AIDS.

Gathering life histories from case studies (see examples in the Guardian, 1995; and Shelby, 1992)[31] on women with HIV/AIDS was my original interest in this research. This was in order to gain responses made by those people who were traumatised by discovering that they had an incurable disease. It was my hope to discover the effectiveness of counselling intervention and to draw recommendations for counselling this group of clients.

However, it became impossible to gain access to this group of people as an "outsider" despite a number of attempts to contact women with HIV/AIDS. The difficulty was twofold. The first difficulty might have rested with the workers' perception that some threat was hidden in the

[31] The Guardian (Thursday, 30th, November, 1995) Marina Cantacuzino talks to women who are HIV positive about what this means to them.
Shelby (1992) investigates what respondents were experiencing as partners of a man who had contracted or died of AIDS.

researcher's request for cooperation when there was no support of a sponsor (an organisation or funding body) for my research. A sponsor can introduce a stranger (that is, the researcher) to a new social world as a guarantor of the stranger's trustworthiness, and can act as a channel for informal social control should the person act in an inappropriate way (Lee 1993).

Second, informal communication with staff working in an organisation for women with HIV/AIDS (1992) reinforced the message that this group of clients had already been suffering from the strain of too many research projects and answering too many questionnaires. Thus, they might have refused to become involved in any further research projects. They might even have refused to open up to their care providers or families/friends. One of the interviewees expressed the same concern for women with HIV/AIDS who refused to meet or talk to anybody (see chapter 6 interviews).

Due to the difficulties discussed above, I needed to be flexible enough to make the necessary adjustments for "unanticipated developments" (Fontana & Frey, 1994) in this study. Thus, instead of case studies on women with HIV/AIDS, I concentrated on workers of women with HIV/AIDS who might be more accessible than their female clients.

The reasons for conducting the preliminary study are based on the literature review. It is evident that women's vulnerability to HIV infection and the numbers of women infected by HIV have been increasing. This suggests the urgent need for medical, social, and emotional support. Counselling is perceived as a significant intervention for the sake of women's psychological well-being when medical and health education interventions are very limited. Thus, it is necessary to investigate the provision of counselling for women with HIV/AIDS.

As discussed before, the implications of a positive test are considerable, and counselling intervention for women with HIV/AIDS is increasing. Therefore, it is essential to investigate the provision and value of counselling for women with HIV/AIDS. HIV counselling is initially provided in medical settings, and individuals who are responsible for HIV counselling are often doctors, health advisors or nurses. Thus, the perceptions of health professionals in working with women with HIV/AIDS is of great importance.

As discussed in Chapter three, different people interpret counselling differently as the result of the diversity of opinion and practice towards counselling. There is an on-going debate about who should

provide HIV/AIDS counselling. This debate focuses on the issue as to whether counselling is a specialist activity that is best provided by trained counsellors or whether anybody can provide such counselling regardless of the level of counselling training being received. Thus, it is necessary to investigate who provides counselling for women with HIV/AIDS and how such counselling is conducted.

Therefore, the formulation of the research question is based on the review of the AIDS literature: "in actual practice, is counselling a central response to women with HIV/AIDS?" The research hypothesis is that:

(1) any attention to the clients' emotional state was often provided through medical attention; and

(2) many helpers (medical staff, nursing staff, social workers, etc.) had had minimal training as counsellors.

Research into the sphere of HIV/AIDS counselling is 'sensitive' as shown in the arguments in Chapter One and the literature review of issues raised by the AIDS epidemic:

- hidden biological, social, and person vulnerabilities; and
- two major sensitive and taboo areas of social function, namely, 'sex' and 'death'.

Therefore, 'sensitivity' potentially affects almost every stage of the research process, from the formulation of a research problem, through the design and implementation of a study, to the dissemination and application of the findings (Lee, 1993).

This chapter also discusses the advantages and disadvantages of quantitative (questionnaire survey) and qualitative approaches (interviewing). Clark-Carter (1997) classifies quantitative methods under three headings: experimenting, asking questions and observing. There seem to be three formats for asking questions: unstructured (or free) interviews, semi-structured interviews and structured questionnaires. The presentation modes are face-to-face, by telephone or through written questionnaire. Respondents might resent having their privacy being invaded by the presence of a researcher who is a stranger. Therefore, a questionnaire survey (being less threatening) was chosen as a primary method for the preliminary study. Semi-structured interviews were chosen as a secondary method.

The results of this preliminary study are described in Chapter six. Chapter seven discusses the data and the limitations of the study, and explains how it led to the recognition of a need for a more

general survey of counsellors' perceptions and expectations when working with clients with HIV/AIDS.

5.1. Structured questionnaire

The questionnaire is an important instrument of research (Oppenheim, 1992). There are a number of advantages in using questionnaires as a tool of data collection (Ary *et al,* 1990; Cohen & Manion, 1995; Clark-Carter, 1997).

- Respondents can fill in the questionnaire themselves, which means that it can save the researcher's time both in interviewing and in travelling to where the respondent lives.
- A standard format can minimise the effect of the way in which a question is asked on the respondent and on his or her response.
- The responses are more immediately quantifiable.
- It can guarantee confidentiality. This may elicit more truthful responses than would be obtained with a personal interview in which subjects may be reluctant to express unpopular points of view.
- It is more economical than the interview in terms of time and expense. Often much of the same information can be obtained by means of a questionnaire.

The disadvantages are that (Lovell & Lawson, 1970; DHSS *et al,* 1987; Ary *et al,* 1990; Oppenhiem, 1992):

- the facial expression and tone of voice of the respondent, the hesitations and repetitions, ..etc. will not be recorded in a questionnaire;
- it is extremely difficult to formulate a series of questions whose meanings are crystal-clear to every individual; the questions may be misinterpreted by respondents;
- there is no guarantee that people have told the truth because of the nature of anonymity;
- there is no control over the order in which questions are answered, no check on incomplete responses, incomplete questionnaires or the passing on of questionnaires to others; and
- individuals who are illiterate cannot be members of samples.

5.1.1. Questionnaire design: closed and open questions

One of the disadvantages of questionnaire surveys is the fixed choice for answers (Klimes *et al*, 1989). Therefore, the combination of closed and open questions was considered necessary when designing this questionnaire.

a) The advantages and disadvantages of closed questions

Closed questions have certain advantages that can increase the likelihood that a questionnaire will be completed (Oppenheim, 1992 and Clark-Carter, 1997):

- they give respondents a context for their replies;
- they are easier for self-administration and quicker to complete; and
- they require no writing but only a tick for the chosen answer(s).

Thus, more questions can be asked within a given length of time and quantification is more straightforward.

However, closed questions may excessively constrain the possible answers (Clark-Carter, 1997) and prevent spontaneity and expressiveness. It is possible that they might guide the respondents' answers in a way that might or might not correspond with subjects' own thoughts. In order to avoid those disadvantages, open questions are also included.

b) The advantages and disadvantages of open questions

The advantage of using open questions is that they are not followed by any kind of choice and the answers have to be recorded in full by the respondents. Another advantage is the freedom it gives to the respondents. Once they have understood the intent of the question, they can let their thoughts run freely, unencumbered by a prepared set of replies. According to Oppenheim (1992), through open questions, the researcher can obtain the respondents' ideas in their own language expressed spontaneously. This spontaneity is often extremely worthwhile as a basis for the formation of new hypotheses, ideas or awareness. However, they may be too time-consuming and difficult to answer for the subjects.

5.2. Interviews

Interviewing was chosen in this study as the secondary method for two reasons (Fontana & Frey, 1994). First, it is one of the most common and most powerful ways researchers use to try to understand human beings. Second, interviewing has found great popularity and widespread use in clinical diagnosis and counselling, where the concern is for the quality of the response. However, interviews are extremely expensive and time consuming (Lovell & Lawson, 1970; Ary *et al*, 1990). Fontana & Frey (1994) suggest that no single interview style fits every occasion or all respondents. This means that interviewers must be aware of respondent differences and must be flexible enough to make proper adjustments. Two kinds of interviews - face-to-face and telephone interviews - were chosen for this study.

5.2.1. Face-to-face interviews

The decision of how to present oneself is very important in interview. According to Fontana & Frey (1994), the researcher's presentation of self leaves a profound impression on the respondent and has great influence on the success (or failure) of the study. Similarly, Oppenheim (1992) suggests that each interviewer must realise that they create an immediate impression on a potential respondent even before he or she speaks. This impression may determine the success or failure of an interview or whether an interview takes place at all.

5.2.2. Telephone interviews

It has been estimated that face-to-face interviewers spend only about one-third of their time in conducting interviews, the remainder of their time being taken up by travel and by locating respondents (Oppenheim, 1992). For the researcher, the most obvious advantage of conducting interviews over the telephone is their low cost, savings in travel expenses and travelling time (Ary *et al*, 1990; Oppenheim, 1992). Speed is another major advantage of telephone interviewing. Because of 'interviewer invisibility' (Oppenheim, 1992) when conducting telephone interviews, some respondents might be able to reply with greater ease. However, the researcher is required to have an excellent telephone manner especially when speaking to those who resent having their privacy invaded by a stranger and who fear for their personal safety (Oppenheim, 1992).

5.2.3. Recording interview data

To overcome the disadvantages associated with note taking during the interview, a complete and accurate recording of the respondent's answers could be made by using a tape recorder (Lovell & Lawson, 1970; Ary *et al*, 1990). Taping has the obvious advantages of recording the subjects' responses verbally, and of freeing the interviewer to participate in the dialogue rather than having to concentrate on note taking (Ary *et al*, 1990). However, people may feel uncomfortable about having their answers taped and may become inhibited and excessively cautious about what they say. Therefore, permission should be obtained before a tape recorder is used (Ary *et al*, 1990).

5.3. The design of questionnaire

The questionnaire was designed to elicit data that could illuminate the following research question: "in actual practice, is counselling a central response to women with HIV/AIDS?"

An 8-page anonymous questionnaire (see Appendix 5.1) was designed with a combination of open/closed questions and factual/awareness questions. Some parts of the questionnaire were drawn from Bond (1991) and Bor *et al*'s (1992) studies. Seven sections were included in the questionnaire.

- personal details,
- experience of working with women with HIV/AIDS,
- HIV positive clients' concerns,
- counselling interventions,
- methods of seeing clients,
- training for counselling, and
- important considerations in establishing a new service to assist women with HIV/AIDS.

5.3.1. Factual and awareness questions

The questionnaire was organised with a set of "factual" questions and "awareness" questions (Oppenheim, 1992) under three sections:

- personal details of the respondents,
- counselling interventions, and
- the concerns for HIV positive clients.

a) Personal details of the respondents

The questionnaire was composed primarily with a set of "factual" questions on 'personal details' of the respondents.

Closed questions using categorical scales (Creswell, 1994) were used, in which respondents were asked to tick the following (see Appendix 5.1):

- their professions (section A);
- main/other organisations offering services to women with HIV/AIDS (section A);
- the length of their working experience with women with HIV/AIDS (section B);
- time spent with clients (section D); and
- the most usual methods used and places in which they saw the clients (section E).

Open questions were used in which respondents were asked to write down their counselling training background (section F). Sections A, E, and F were selected from Bond's questionnaire (1991).[32]

b) Counselling interventions

Section D, questions 1 to 3 were designed to discover subjects' counselling interventions. There is an assumption in medical settings in the UK that practitioners should favour Rogers' non-directive counselling (Sibbald *et al*, 1993; Friedli *et al*, 1997; Harvey *et al*, 1998). Therefore, these three questions were designed to discover respondents' ability to distinguish activities between information-giving, advice-giving and client-centred counselling, and the time they divided between practical, medical and personal needs of their HIV positive clients.

[32]Bond (1991) British Association for Counselling / Department of Health Joint Project. *Counselling People living with HIV/AIDS: National Survey, Consultation and Report.* Leeds Consultation Day on Tuesday 1 May 1990. Questionnaire for Participants

A number of problems frequently faced by people with HIV/AIDS were listed in Section D, Question 4. They consisted of 9 items on practical issues, 7 items on medical issues, and 25 items on personal issues. Practical issues - items 1 to 9, medical issues - items 3 to 5, and personal issues - items 1, 4, 5, 6, 7, 18, 19, 20, 21, were adopted from a category of practical needs, personal issues, and counselling about HIV in Bor *et al*'s (1992)[33] study. The rest of the items were selected from discussions in Chapter Two of issues related to women's HIV positive status.

c) The concerns for HIV positive clients

Sections C and G were open and "awareness" questions. Section C provided opportunities for:

a) respondents to indicate the importance of the issues most frequently raised by women with concerns arising from their own HIV positive antibody status; and
b) discovering respondents' difficulties in responding to their positive clients.

Section G provided opportunities for workers' suggestions for establishing a new service to assist women with HIV/AIDS (see Appendix I: questionnaire). Rank-ordered scales (Creswell, 1994) were used (from the most importance to the least important, or the most difficult to the least difficult issues).

5.4. Sample selection

The preliminary study was carried out among individuals who were responsible for HIV counselling in STD clinics and HIV counselling centres (Coyle and Soodin, 1992). Those to whom the questionnaire was sent fulfilled a variety of occupational roles as doctors, health advisers, HIV/AIDS counsellors, nurses, and practising counsellors (Bond, 1991; Brown-Peterside *et al*, 1991; Burnard, 1992b; Coyle & Soodin, 1992).

Twenty-nine organisations[34] offering services to people with HIV/AIDS in the UK were selected from

[33]Bor et al (1992) *Social care services for patients with HIV at a London teaching hospital: an evaluation* (p384, table 3)

[34] These twenty-nine organisations included 16 Hospitals, 11 Voluntary organisations, and 2 Social service

three sources:

- lists of delegates attending a national conference concerning paediatric AIDS in the UK in 1993;
- lists of organisations providing support for people with HIV/AIDS provided by an AIDS counselling training course in the UK in 1991;
- a directory of HIV/AIDS counselling-related agencies enclosed in a national report on "HIV Counselling" (Bond, 1991).

Snowball sampling is useful for sampling a population where access is difficult (Morrison, 1993). Thus, snowball sampling was used in this preliminary study because of its sensitive nature (Oppenheim, 1992; Morrison, 1993; Cohen & Manion, 1995; Mertens, 1997) (see p. 109). That is, the researcher identified a small number of individuals who had the characteristics chosen for the sample (Morrison, 1993; Cohen & Manion, 1995; Mertens, 1997). These people were then used as informants to identify others who qualified for inclusion and these, in turn, identified others. However, it is difficult to know how accurately these represent the population of concern (Oppenheim, 1992). The sample is not a random, representative sample, but rather an "opportunity sample" (Bell *et al*, 1984), based on the availability and potential willingness of workers in the field to respond.

5.5. Preparing a covering letter

The aim of the research was described in the covering letter. "Confidential" was marked on the right corner of the cover page. It was emphasised that confidentiality (Oppenheim, 1992) would be kept as a central issue of this research in order to encourage and gain the trust of the subjects. Lydeard (1996) raises an important issue that the perceived value or general applicability of the research project, determines the response of a survey. When I questioned myself about whether my research solely concentrated on advancing knowledge without any declared usefulness (Wenger, 1987) , I concluded that I hoped to provide a contribution through this study not only to people providing HIV/AIDS counselling in general, but specifically to my own country, Taiwan. Here the needs of women with HIV/AIDS is urgent and under-researched. I communicated this intention to the respondents.

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departments.

The basic principle governing data collection is that no harm should come to the respondents as a result of their participation in the research. Ethical concerns for this study include (Oppenheim, 1992; Fontana & Frey, 1994):

- right to privacy - protecting the identity of the subject;
- informed consent - consent received from the subject after he or she has been carefully and truthfully informed about the research; and
- protection from harm - physical, emotional, or any other kind.

5.6. Procedures

A pilot study was not conducted in the preliminary study due to the difficulty in accessing the chosen sample (see p. 109) and the low numbers of respondents working with women with HIV/AIDS. The preliminary study was carried out in six stages (between November, 1995 to May, 1996) and each stage is summarised in Table 5.1 below.

Table 5.1: Summary table of development for the preliminary research

Stages	Timing	Procedures
I	Nov. 1995 to Jan. 1996	Two or three questionnaires, a general letter to workers, and a reply letter were sent to each organisation. A total of 65 questionnaires were sent.
II	end of Jan. 1996	A reminder letter was sent to the entire sample.
III	Mar. 1996	Two more organisations were approached, stage I was repeated. A total of 5 questionnaires were sent.
IV	mid-Feb. to early Mar. 1996	Face-to-face or telephone interviews were carried out and tape recorded.
V	April 1996	A tape transcript was sent to each interviewee.
VI	mid-May 1996	A reminding letter was sent to the interviewees to return the transcript after checking.

Stage I Twenty-seven organisations were approached from Nov. 1995 to January 1996. Two letters and two or three questionnaires were enclosed to each organisation. The first letter, inviting workers' participation, indicated a) the aims of the research; and b) the request to respondents to ask relevant colleagues to complete the questionnaire (Appendix 5.2). The second letter asked whether the respondents were willing to offer an interview or pass on more questionnaires to their colleagues (Appendix 5.3). A total of 65 questionnaires were sent.

Stage II As the questionnaire was completed anonymously, it was impossible to know who did not return the questionnaire, a reminder was therefore sent to the entire sample. Thus, a second letter was sent to each organisation at the end of January 1996 reminding them that their reply was due by the end of February (Appendix 5.4). Another letter written by my two supervisors expressing their support for this research was enclosed (Appendix 5.5). A stamped addressed envelope was also enclosed to facilitate a response.

Stage III The letters and questionnaires to one organisation were lost in the post; and one more contact address was given to me in early March by one worker in this field. Thus, two more organisations were approached in March 1996 with a general letter to workers and 5 copies of the questionnaire.

Stage IV Three workers who offered face-to-face or telephone interviews and agreed to be tape-recorded were interviewed between the middle of February and the first week of March 1996. The interviews took place for 30 to 45 minutes and were semi-structured with open-ended questions in two steps.

- *Step 1.* If the situation allowed, I spent some time before or after the interview in a general chat with the interviewee (Jenkins, 1993). I attempted, wherever possible, to establish some sort of 'co-membership' with the individual concerned (Wenger, 1987). The other interview technique was a conscious attempt to adopt the 'normal talk' strategy described by Jenkins (1993). The 'normal talk' interview strategy was designed to lower the guard of the respondents so that they might be more open and honest in their responses (Jenkins, 1993). By this I attempted to conduct the interview as though it were an informal, 'ordinary conversation'.
- *Step 2.* I explained the aim of this research to the respondent. Then, I began the interview by "breaking the ice" with general questions and gradually moved on to more specific ones (Mertens,

1997)(see Appendix 5.7). I also tried, in so far as this was possible, to allow the natural flow of the 'conversation' to dictate the order in which the questions were asked.

Stage V A tape transcript was sent to each interviewee in April 1996 with a particular emphasis on the issue of confidentiality. The interviewees were informed that the tapes would be wiped after the completion of transcripts for this study.

Stage VI In the middle of May 1996, a reminder letter was sent to remind the interviewees to return their transcripts after checking (see Appendix 5.6).

The results of this preliminary study are presented in Chapter six. Chapter seven discusses data elicited from the methodology and the limitations of this study that led to the recognition of a need for a more general survey of counsellors' perceptions and expectations when working with clients with HIV/AIDS.

CHAPTER SIX: Results

This chapter presents the results of the returned questionnaires and interviews in descriptive forms. Quotes directly taken from the respondents are typed in *"Italics"*.

6.1. Data analysis of questionnaires

Twelve out of seventy questionnaires (section 5.6. Stages I and III) were returned. As the questionnaire was completed anonymously, it is unknown whether each organisation returned one or more questionnaire. Assuming one reply from each organisation, the response rate of 12 out of 29 organisations is 41%. Unfortunately there was no way of telling whether these respondents were representative of the total sample. The results will be presented under five sections: respondents' personal characteristics, HIV positive clients' concerns, respondents' counselling interventions, respondents' methods of seeing clients, and respondents' training in counselling.

6.1.1. Respondents' personal characteristics

The personal characteristics of respondents are presented in Table 6.1. Those who returned the questionnaire were responsible for providing HIV counselling in their work places and all fulfil the characteristics of the various roles described in sampling, namely HIV counsellor, clinical psychologist, nurse and health advisor, doctor, and social worker. The respondents indicated 4 main organisations (hospital, HIV voluntary agency, social service department, and international programme design for health and HIV/AIDS) and 3 respondents indicated other organisations (anywhere required by clients, hospital and home) in which they offered services to women with HIV/AIDS. All the respondents were initially experienced professionals in the field of HIV/AIDS (with a mean of 6 years' working experience). The majority of the respondents had seen over 20 patients at the time of replying to my questionnaire.

6.1.2. HIV positive clients' concerns

Two lists of items were reported by respondents regarding issues most frequently raised by women with concerns arising from their own HIV positive status, and issues they found difficult when responding to their HIV positive clients.

a) Issues frequently raised by women with HIV/AIDS

Respondents reported 67 items which were important issues raised by women with HIV/AIDS using rank-ordered scales (1 = most important, 5 = least important). These items were categorised in table form (Tables 6.2 and 6.3) under three groups: practical, medical, and personal needs, based on the literature review and face validity. However, it is important to bear in mind that some items might overlap across the categories, for instance, "care of children" could be both practical and personal needs. More than 2/3, 47 items (70%), were personal needs. Respondents might list more than one issue within each rank order.

Table 6.1: Personal characteristics and working experience of respondents

	Number of respondents
Profession (n = 12)	
HIV counsellor	1
Clinical psychologist	2
Nurse and health advisor	3
Doctor	3
Social worker	3
Main organisation(s) (n = 12)	
Hospital	6
HIV Voluntary agency	4
Social service department	1
International programme design for health, HIV/AIDS	1
Other organisation(s) (n = 3)	
Anywhere required by clients	1
Hospital	1
Home	1
Length of working experience (n = 12) (mean = 6 years)	
1 year	1
1-5 years	6
6-10 years	3
over 10 years	2
Number of HIV positive clients seen (n = 12)	
11-15	1
Over 20	11

Table 6.2: Most frequent issues raised by women

Women's concern	Items	%
Practical	14	21%
Medical	6	9%
Personal	47	70%
Total	67	100%

Table 6.3: Practical, medical, and personal issues frequently raised by clients

Order of importance	Practical issues (n = 14 items)	n
*1	Children care services i.e. day care, nursery, child minding	1
*2	Welfare of children or family	3
	Refugee issues	1
	Extra finance	1
	Domestic help	1
*3	Finance	1
	Housing	1
	Refugee status	1
	Transport	1
*4	Finance	1
	Night sitting when ill	1
*5	Food or basic needs	1
	Medical issues (n = 6 items)	
*1	Illness	1
*2	Immediate health needs	1
	Treatment	1
*3	Disease progression & loss of control	1
*4	Illness	1
	Maintaining health	1
	Personal issues (n = 47 items)	
*1	Care of children: Coping with infected/ affected children	4
	Confidentiality/disclosure	2
	The future: further plan for children	2
	Bereavement	1
	Death	1
	Emotions	1
	Whether future or existing children will be or have been infected	1
	Impact on self	1
	Body image i.e. weight loss	1
	Telling children about their HIV status	1
	Reproduction decision	1
	Relationship problems	1
*2	Children related issues: allowing children to go into care	2
	Pregnancy issue: if they have no partner - whether they will find appropriate partner to father child	2
	Not being able to work	1
	Women support group	1
	Fear of disclosure	1
	How to share information with family and children	1
	If they have a partner--partner's status and/or risk they pose to partner	1
*3	Confidentiality: telling new partners/friends about their HIV status	4
	Children: having children	2
	Being a carer and need for support	1
	Having a normal life i.e. going out, socialising	1
	How they will be treated in hospital i.e. will HIV status be disclosed & what will staff's reaction be	1
	Partner support	1
*4	Relationship problems with partners or husbands	3
	Having a normal life	1
	Sharing information/who to tell	1
*5	Guilt, grief, and loss	1
	Having someone to talk to	1
	Isolation	1
	Need to talk to other women	1
	Who to tell - professionals	1
	Sexuality	1

*Order of importance: 1 = most important, 5 = least important

b. Issues respondents found difficult in responding to HIV/AIDS clients

Respondents identified 33 items as difficult when responding to HIV/AIDS clients. Rank-ordered scales were used (1 = most difficult, 5 = least difficult). These items were categorised under three groups: practical, medical, and personal needs in table form (Tables 6.4 and 6.5) (section C.a on how items were categorised). 20 items (61%) were personal needs. Respondents might list more than one issue for each order of difficulty.

Table 6.4: The frequency distribution of the difficult issues reported by respondents

Difficult issues	Items	%
Practical	11	33%
Medical	2	6%
Personal	20	61%
Total	33	100%

Table 6.5: Difficulties reported by counsellors in responding to practical, medical, and personal issues

	Practical issues (n = 11 items)	n
*1	welfare issues	3
	24 hr - 7 day a week home care	1
	Practical & social issues	1
	Financial issues	1
*2	Environmental change	1
	Immigration issues	1
	Night sitting when terminal ill	1
*3	Support + services: helping develop supportive networks informal + formal	1
*5	Re-housing	1
	Medical issues (n = 2)	
*2	Treatment	1
*3	HIV testing for partners	1
	Personal issues (n = 20)	
*1	Depression often organic in origin	1
	Encouraging partners to involve children in decision making	1
	Involving children in discussions, i.e. future care arrangements	1
	Telling their children about their HIV status	1
*2	Allowing children to go into care	1
	Giving people hope that they will continue being healthy	1
	Resolving conflicts about arrangements when open discussion has not been possible	1
	Relationships problems	1
*3	Family inclusion	1
	HIV testing for partners	1
	Preparation for death	1
	Telling new partners/friends about their HIV status	1
*4	Community inclusion	1
	Giving people hope	1
	Helping clients accept diagnosis	1
	Informing children	1
	Their relationship problems with partners or husbands	1
*5	Bereavement	1
	Personal 'ownership' of the future	1
	Who to tell - professionals	1

*Order of difficulty: 1 = most difficult, 5 = least difficult

6.1.3. Respondents' counselling interventions

Respondents reported their time spent with HIV positive clients in a normal working week; the percentage of time spent in information-giving, advice-giving, and client-centred counselling; the percentage of time spent in addressing practical needs, medical needs, and personal needs of clients.

a) Time spent with HIV positive clients

Table 6.6 displays a wide range of hours that workers spent with HIV positive clients in a normal working week, vary from 0 to 32 hours.

Subject a (clinical psychologist) spent 70-80% of a normal working week with families living with HIV infection. Assuming she was working full-time for 40 hours per week, she will have spent 28-32 hours working with HIV/AIDS clients.

Table 6.6: Hours spent with HIV/AIDS clients in a normal working week and the percentage of the total time spent on giving information and advice, and counselling

Subjects	working hours in a week	Information-giving (%)	Advice -giving (%)	Client-centred counselling (%)
a. Clinical psychologist	28-32hours			
b. Doctor	1 hour	30	30	30
c. Doctor	less than 1 hour	60	20	20
d. Nurse + health advisor	10 hours	20	20	20
e. Doctor				
f. Social worker	15 hours	25	50	25
g. Nurse + HIV nurse counsellor	20 hours	5	10	15
h. HIV counsellor	6 hours	15	5	80
i. Social worker	10 hours	20	45	35
j. Social worker	20 hours	70	20	10
k. Voluntary counsellor + health advisor	2 hours	40	40	20
l. Clinical psychologist	0-20 hours			

Note: In three cases (subjects b, d, and g) the figures do not add up to 100 percent. It is not clear whether this was due to respondents having other jobs, or not understanding the request in the question.

b) Time spent on practical, medical, and personal needs

Table 6.7 records the time nine respondents spent on the three helping activities (information-giving, advice-giving, and client-centred counselling) in responding to clients' practical, medical, and personal needs. As the task to separate time spent on practical, medical and personal needs of clients was extremely difficult, the validity of respondents' answer was questionable. It is likely that some figures below represent low validity.

Table 6.7: Time divided between practical, medical, and personal needs

Time divided between three helping activities	Practical needs (%)	Medical needs (%)	Personal needs (%)	Total (%)
(1) Information-giving (n = 9)	30	30	30	90
	10	80	10	100
	33.3	33.3	33.3	100
	50	5	45	100
	40	30	30	100
	2	90	8	100
	45	5	50	100
	80	10	10	100
	30	30	40	100
Mean	35.6	34.8	28.5	98.9
(2) Advice-giving (n = 9)	30	30	30	90
	10	80	10	100
	33.3	33.3	33.3	100
	20	5	75	100
	20	50	30	100
	3	80	7	90
	50	0	50	100
	50	0	50	100
	30	30	40	100
Mean	27.4	34.3	36.2	97.9
(3) Client-centred counselling (n = 9)	20	20	60	100
	10	80	10	100
	33.3	33.3	33.3	100
	50	5	45	100
	20	40	40	100
	10	30	60	100
	30	0	70	100
	50	0	50	100
	10	10	80	100
Mean	25.9	24.3	49.8	100

Note: In several cases the figures do not add up to 100 percent. It is not clear whether this was due to respondents having other jobs, or not understanding the request in the question.

Tables 6.8 to 6.10 indicates how many respondents reported spending "a lot of time" on information-giving, advice-giving, and client-centred counselling respectively in each of the areas listed.

(a) Practical issues

Table 6.8: Amount of time spent in responding to practical needs

Practical needs	number of subjects (n = 9)		
	Information-giving	Advice-giving	Client-centred counselling
(1) Employment advice	0	0	1
(2) Furniture/household appliances	1	2	2
(3) Housing	3	3	4
(4) Immigration/visas	3	3	4
(5) Income support	1	1	2
(6) Legal problems	1	1	2
(7) Mobility allowance	1	1	2
(8) Other financial benefits	2	2	3
(9) Payment of bills	2	2	3
(10) Others:	1	1	1
Changes in attitude	1	1	1
Changes in behaviour	1	1	1

(b) Medical issues:

Table 6.9: Amount of time spent in responding to medical issues

Medical issues	number of subjects (n = 9)		
	Information-giving	Advice-giving	Client-centred counselling
(1) Vertical transmission from mothers to babies	0	0	1
(2) HIV antibody testing (post-test, positive results)	3	3	4
(3) Sterile needles, syringes, water	0	0	0
(4) Detoxification prescriptions	0	0	0
(5) Treatment	3	2	2
(6) Preventing transmission of HIV	3	3	2
(7) Avoiding pregnancy	0	0	0
(8) Others:	0	0	0
Opportunistic infections	1	1	1
Prognosis	0	0	0
Meaning of test results	1	0	1
Illness in children	1	1	1

(c) Personal issues:

Table 6.10: Amount of time spent in responding to personal issues

Personal issues	number of subjects (n = 9)		
	Information-giving	Advice-giving	Client-centred counselling
(1) Anxiety	4	3	7
(2) Being expelled from home	1	2	1
(3) Caring for infants with HIV/AIDS	4	4	5
(4) Coming off drugs	0	0	1
(5) Coping with HIV	5	5	8
(6) Depression	4	4	3
(7) Family problems	4	4	6
(8) Feeling of guilt	2	2	2
(9) Impact of child birth	0	0	1
(10) Informing family of HIV status	4	4	7
(11) Informing sexual partner of HIV status	1	1	3
(12) Loss of health	4	3	6
(13) Loss of self-esteem	3	3	3
(14) Physical assault/abuse	0	0	1
(15) Preparation for death of the child	3	3	5
(16) Preparation for death of a partner	3	4	5
(17) Preparation for death of self	4	4	6
(18) Relationship problems	2	3	5
(19) Relaxation training	0	0	0
(20) Sexual problems	0	0	0
(21) Sleeping problems	3	2	3
(22) Stress	3	3	4
(23) Suicidal ideations/attempts	2	2	3
(24) Support in crises	3	3	5
(25) Uncertainty about the baby's HIV status	1	1	2
(26) Others:	1	1	1

6.1.4. Respondents' methods of seeing clients

Half of the respondents indicated that their most usual method for seeing HIV positive clients was "mostly by appointment" (Table 6.11). One respondent did not answer this question.

Table 6.11: Most usual method of seeing clients

Most usual method used	Number of respondents
(1) by appointment only	2
(2) mostly by appointment	6
(3) mostly without appointment	2
(4) without appointment	0
(5) any combination - varies	1
Total	11

Four respondents stated that the "client comes to my centre/office" was the most usual place where their HIV positive clients were seen (Table 6.12). One respondent did not answer this question.

Table 6.12: Most usual place where HIV positive clients were seen

Most usual place	Number of respondents
(1) Client comes to my centre/office	4
(2) Client comes to my home	0
(3) I go to see clients in their homes	3
(4) I go to see clients in hospital	1
(5) Client comes to my centre/office + I go to see clients in their homes	1
(6) Client comes to my centre/office + I go to see clients in their homes + I go to see clients in hospital	2
Total	11

6.1.5. Respondents' training in counselling

Respondents reported information about whether they were accredited counsellors; the general counselling and HIV counselling training they had received; the level of adequacy when providing HIV/AIDS counselling; and aspects of counselling in which they would like to receive further training.

a) Accredited counsellor

Only one out of twelve respondents was an accredited counsellor. One subject questioned what "accredited counsellor" meant. One wrote that most counsellors were *"not professionally qualified but were qualified through orientation/education/experiential learning in a context of cultural congruency"*.

b) General counselling and HIV counselling training

The results reveal a general lack of training in counselling and HIV counselling in particular. Only 58% (7/12) of the respondents had received training in counselling. They listed four groups of 21 separate forms of counselling training they had received, namely general counselling, psychology, HIV/AIDS counselling, and health profession. Of these, only 5 out of 21 were about HIV counselling (Table 6.13). The general lack of training in HIV counselling is evident from the relatively short length of training they received which varied from 72 hours, 54 hours (3 hours a week for 18 weeks), 35 hours, to 30 hours.

Table 6.13: Summary of all kinds of counselling training received

Course title	Length of training in hours	Counselling formally assessed	Training about HIV Counselling
General counselling: (n = 7)			
Basic Counselling	30 hrs		
Counselling Foundation	2-3 hrs weekly		
Bereavement Counselling	14 hrs		
Counselling Sandwich Courses (practice, advice, counselling, education)			
Family Therapy	5/wk x 2 yrs	yes	
Cert. in Counselling		yes	
Personal Potential/Awareness (private psychotherapist)	3 hrs x 18/52 wks		
Psychology: (n = 8)			
BA Psychology (n = 2)			
BPS Clinical Psychology		yes	yes
MSc Counselling Psychology		yes	
Hons (psy) Major Counselling		yes	
Ph.D. Psychology			yes
HIV/AIDS Counselling (n = 5)	30 hrs		yes
HIV/AIDS counselling			
Basic HIV Counselling	3 hrs x 18/52 wks		yes
Counselling People Infected & Affected by HIV/AIDS	72 hrs		yes
HIV/AIDS Courses (practice, advice, counselling, education)	30 hrs		yes
Motivational Interviewing (National AIDS counselling unit)	35 hrs	yes	yes
Health profession (n = 4)			
BSc Hons Nursing			
Diploma Health Visiting			
Health Advising Course	5/wk + 3 months supervising	yes	yes
Health Advisor Training	3/52 wk		

c) Respondents' feelings of adequacy in providing counselling

Table 6.14 describes participants' feelings about the adequacy with which their training prepared them for HIV/AIDS counselling. Half of the respondents felt that their training prepared them adequately or very adequately for HIV/AIDS counselling. Although one respondent felt inadequate, she expressed the view that formal counselling training is not the only way to prepare for such work. Another respondent felt "very inadequate", expressing her feeling of helplessness in providing a counselling service when faced with the shortage of staff in her work place and lack of training. One respondent did not answer this question.

d) Respondents' perceptions about the need for further counselling training

Three respondents believed that further counselling training was not necessary but self-exploratory training and a self help group were. More than half of the respondents (7/12) indicated 10 aspects of counselling for which they would like to receive further training (Table 6.14).

Table 6.14: Respondents' feelings of adequacy for HIV/AIDS counselling and aspects of counselling in which respondents would like to receive further training

	Number of respondents
Level of adequacy (n = 11)	
Very adequate	1
Adequate	5
Not sure	3
Inadequate	1
Very inadequate	1
Aspects of counselling requiring for further training (n = 10)	
All kinds of counselling	1
Bereavement counselling	1
Breaking bad news	1
Developing skills to move people on (for example, in accepting diagnosis)	1
HIV/AIDS counselling for all people infected and affected	1
Grief counselling on aspects of self-esteem	1
Grief and loss	1
Further counselling training is not necessary	3

6.2. Interviews

The three interviewees were either health advisors or specialist nurses. These are normally the professionals who provide HIV pre- and post-test counselling in the UK. Their views are significant as they are taking on a central role in introducing people to counselling and to the implications of HIV/AIDS. Two offered face-to-face interviews and one offered a telephone interview, and all agreed to be tape-recorded. To ensure accuracy, quotes taken directly from the interviews are typed in *"Italics"*. Several important issues regarding interviewees' counselling experiences are described under four categories:

- interviewees' background,
- interviewees' ways of counselling,
- difficulties faced by interviewees when offering counselling, and
- the advantage of receiving counselling training.

6.2.1. Interviewees' background

Table 6.15 summarises the three interviewees' background regarding their working experience with people with HIV/AIDS. One of the interviewees did not only provide counselling for people with HIV/AIDS but also for their family, even after the client had died. Their mean for working experience with people with HIV/AIDS is 3.8 years. Two interviewees had received humanistic counselling training. The number of HIV/AIDS female clients seen by them ranged from over 20 to over 80.

Table 6.15: The interviewees' background in working with people with HIV/AIDS

Background	Interviewee I	Interviewee II	Interviewee III
Length of working experience	1 year	1-5 years	6-10 years
training in counselling	not known	Humanistic	Humanistic
number of patients with HIV/AIDS in their work place	over 80	over 20	Not known

6.2.2. Interviewees' ways of counselling

When asked how they counselled patients, they replied that a large part of their role initially would be giving information and advice, rather than counselling. A significant aspect of their job was *"using counselling skills and being there for them* [the clients]*"*.

They stressed the importance of information-giving: *"giving them* [the clients] *information so they have got control over their lives...."* They perceived that information-giving was not counselling, however, they had to give information to people or they would go away feeling very frustrated.

They believed their role in working for people with concerns about HIV/AIDS was to empower them in developing good self-esteem. The ways they aimed to empower their clients were:

- telling them not to put themselves at risk and to use protection while having sex; and
- looking at what strengths they had and making them aware of these strengths.

In other words, they combined directive and non-directive approaches.

One adopted the humanistic approach to counselling saying: *"you make sure that they* [the clients] *have control, you don't take their decision making aspects of life away from them,.. You*

make them feel empowered, and be able to come to solutions and make decisions themselves." One found her role very useful when obtaining knowledge about palliative care, pain and symptom control, as well as offering emotional support.

6.2.3. Interviewees facing difficulties in counselling people with HIV/AIDS

A number of difficulties in counselling people with HIV/AIDS were expressed as follows.

- Clients denied their diagnosis. Counselling was extremely difficult when clients were ill with AIDS and had never accepted their diagnosis.
- Clients refused to tell relatives about their diagnosis. Counsellors could not talk openly when going into homes where the client's diagnosis was kept from family members. The situation became more awkward after the death of the client when the interviewee carried out bereavement counselling with the family members.
- Counselling for mothers of HIV positive infants (who were infected through vertical transmission) was most problematic. Some women discovered their diagnosis through their children's HIV status. Yet, some women found it too traumatic and refused to be tested after knowing their children's HIV status.
- Difficulties arose on the issue of placing children for adoption when counselling women with AIDS - when the mother would not let go of her children, yet was not able to care for them at home.
- Clients with AIDS were deteriorating so quickly that counselling was impossible.
- The difficulty centred on helping clients face death and talk openly about death instead of denial.

6.2.4. The advantage of receiving counselling training

One interviewee, who had been working for more than 20 years in her job, felt totally unskilled in providing counselling to her clients; that was why she had been receiving humanistic counselling training. She thought that having counselling training had helped her tremendously, especially in the issue of the counsellor empowering clients rather than the counsellor taking the responsibility on herself.

6.2.5. Carers withdrawal from caring at the late stages of illness

One interviewee said: *"...people [carers] don't want to be part of the network anymore because of facing with each stage of the illness, or because they are [HIV] positive [themselves]... When the patients become very ill, sometimes, other people, who have been friendly with them who are also HIV positive, don't want to visit them, because they will be left to face with their own death. It's quite common. And those patients can't understand why people they were quite friendly with won't contact them any more."*

Conclusions

"In actual practice, is counselling a central response to women with HIV/AIDS?"

Since the majority of the respondents lacked training in counselling, the results demonstrated that most counselling provided by this sample of counsellors for women with HIV/AIDS was not carried out by trained counsellors. This supports the research hypothesis that many helpers who were responsible for providing counselling to women with HIV/AIDS had minimal training as counsellors.

Moreover, it is clear that the respondents spent more time giving information and advice even though they reported that the concerns raised by women with HIV/AIDS were more on personal needs rather than medical and practical needs. This appears to support the hypothesis that medical attention was often the prime means for addressing emotional conditions of the clients. Thus, the results suggest that counselling was not a central response to those clients.

The next chapter discusses the results and the limitations of this study that led to the recognition of a need for a more general survey of counsellors' perceptions and expectations when working with clients with HIV/AIDS.

CHAPTER SEVEN: DISCUSSION OF PRELIMINARY STUDY

Given my initial curiosity about the contribution counselling was making and should be making to the care of women with HIV/AIDS, and having carried out a detailed review of literature (chapters 1 to 4), a methodology that would permit me to carry out an original investigation was derived in chapter 5. This in itself proved a major challenge, given the sensitive nature of the material which I aimed to obtain. According to the results described in chapter six, it is extremely doubtful whether counselling was a central response to women with HIV/AIDS in terms of workers' everyday practice.

My research hypothesis was that: any attention to the clients' emotional state was often provided through medical attention; and many helpers who provided counselling to people with HIV/AIDS had had minimal training as counsellors. This chapter focuses on detailed discussion of the questionnaires and interviews, and on the limitations of the study. Finally, a number of significant issues are raised from this preliminary study that underline the importance of investigating the perceptions of experienced and trainee counsellors with respect to their role when working with clients with HIV/AIDS.

7.1. Discussions from questionnaires and interviews

Twelve questionnaires were returned and three interviews were conducted, and are discussed in this section.

7.1.1. Hours spent with HIV positive clients

The hours that workers spent with HIV positive clients in a normal working week varied from 32 hours to less than one hour, although it was unknown whether the hours reported by the respondents here referred to providing HIV counselling. If this was the case, it was still unknown whether this referred to pre-test, post-test, or follow-up HIV counselling.

The respondent who spent the longest hours with HIV positive clients in face to face sessions was a clinical psychologist who spent 28-32 hours with clients in a normal working week. Three other respondents, who spent a substantial period with HIV positive clients, were a clinical nurse specialist (who was also a HIV nurse counsellor), a social worker, and a clinical psychologist. They all spent 20 hours with clients in a normal working week. If the time spent with clients reported by the respondents was related to HIV counselling, then these findings suggest that respondents in this study spent more time than the 7 to 14 hours per week (half an hour or an hour per session and 14 counselling sessions per week) reported by Coyle & Soodin's (1992) for counselling for pre-test and post-test positive or negative results. However, this comparison needs to be treated with caution. The number of clients seen in a week was not reported in Coyle & Soodin's study, thus it was not clear whether the hours of HIV counselling were spent on one client or more than one.

It was anticipated that medical doctors spent very little time in face to face sessions with HIV positive clients. Among the respondents, two doctors spent the least time of one hour or less than one hour in a normal working week.

One respondent who was not able to answer how much time she spent with women with HIV/AIDS, raised an important issue, as she wrote: *"impossible to say - much of my work involves women of unknown status but with some HIV related concerns as those unknown, they are positive"*. This confirms Hutton and Wissow (1991), Cantacuzino (1995) and Sobo's (1995) findings that many women who did not know their HIV status had already been infected by the virus. One of the interviews conducted for this study also supported this finding. One interviewee reported that mothers of HIV positive infants did not always go for testing themselves since they found it too traumatic at the time. A question is raised here: how can counsellors help those clients who may have been infected and are resistant to HIV testing?

7.1.2. Three helping activities

In order to discover the extent of counselling available to HIV positive clients in workers' everyday working experience, clear distinctions need to be made between the three helping activities: information-giving, advice-giving and client-centred counselling. However, the two clinical psychologists who spent longer times with HIV positive clients in face to face sessions (more than 32

hours and 20 hours), found it impossible to answer the questions in D2 (appendix I) on the division of the three helping activities.

This inability or unwillingness to distinguish between the three helping activities suggests that while counselling has been largely client-centred in the medical setting, HIV counselling has not been so. This also suggests a possible confusion about the nature of counselling among health professionals who provide HIV/AIDS counselling. As the models of counselling training respondents had received were not recorded in this study, it was unknown whether respondents had been trained in models other than the client-centred, and thus were not able to distinguish the three activities. However, as the design of the questionnaire was problematic, the task was too difficult and time consuming for the respondents (more details in section 7.2.1b, e and 7.2.2).

Moreover, apart from one HIV counsellor, the majority of workers spent very little time in client-centred counselling (range between 10% to 35%). Although this HIV counsellor spent 80% of her time in client-centred counselling with HIV positive clients, this is still relatively few hours as she only worked 6 hours in a normal working week. It was previously pointed out that two other workers also spent 20 hours a week with HIV positive patients. One of them, a social worker, spent most of her time in information-giving (70%) but very little time in client-centred counselling (10%); and another one, a clinical nurse specialist (also a HIV counsellor), spent only 15% of her time in client-centred counselling. It is unknown whether respondents practised other approaches to counselling.

7.1.3. Respondents' counselling experience in everyday practice

A number of difficulties in counselling people with HIV/AIDS were expressed by the respondents. For HIV/AIDS workers, the majority of the difficult issues in responding to their HIV positive clients were personal needs, then practical needs, and lastly, medical needs (Tables 6.4 and 6.5).

Workers reported that the concerns raised by women with HIV/AIDS were more on personal needs rather than medical and practical needs (Tables 6.2 and 6.3). However, apart from one HIV counsellor, the respondents spent more time in providing information and advice to their clients. This suggests that in their actual practice, workers who were responsible for HIV counselling combined directive and non-directive approaches to counselling. The same results were found in interviews.

However, is it possible to combine a client-centred approach with a directive approach? (see Chapter 2)

7.1.4. Respondents' feelings of adequacy in providing counselling

Individuals, who were responsible for HIV counselling in this study, generally lacked training in counselling. However, more than half of the workers felt that their training had prepared them adequately for HIV/AIDS counselling. This suggests that workers did not believe that formal counselling training was necessary for working with people with HIV/AIDS. Although seven workers indicated a number of aspects of counselling for which they would like to receive further training, two workers expressed their views that further counselling training was not necessary but self-exploratory training and self help groups were.

- One respondent stressed that self-exploratory learning and experiential learning were more significant than counselling training in carrying out her job by exploring issues herself and participating in the training of others and continually learning, continually updating her knowledge. She said that she would not necessarily find further formal training useful.
- Another stressed the importance of developing the skills of entry into homes and communities and facilitating group discussions. She suggested that emphasis needs to be put on facilitating (family & community) group discussions by using a counselling approach to help the clients to make decisions.

Two workers felt inadequate in providing HIV/AIDS counselling. One of them expressed the view that her training was 'inadequate' when offering HIV/AIDS counselling. However, she did not consider that formal training for workers as the only option for preparation for counselling. Another worker, expressing her feeling of helplessness in providing a counselling service when facing the shortage of staff and lack of training, felt 'very inadequate'.

7.1.5. Accredited counsellor

Eleven out of 12 respondents, who returned the questionnaire, were not accredited counsellors. One of them was not clear what "accredited counsellor" meant. Another believed that most counsellors were *"not professionally qualified but were qualified through orientation/ education/experiential learning in a context of cultural congruency"*. This discloses the respondents' limited understanding of what counselling really means, and what counsellors have to offer (chapter 2).

7.2. Limitations of the study

Several limitations were identified under the headings of sampling, questionnaire, and interview.

7.2.1. Sampling

I used a small convenience sample among health care providers (see sampling). It is possible that those individuals already differed in beliefs and attitudes towards HIV/AIDS counselling from counsellors in other settings (see chapters 3 and 4). Thus, respondents' answers might be biased. Moreover, the purposive sampling procedure decreases the generalisability of findings. This study will not be generalisable to all areas of HIV/AIDS counselling.

Fifteen out of twenty-nine organisations (51.7%) responded to the research by providing comments on the questionnaire explaining the reasons why they were not able to participate in this research (Table 7.1). Some of them wrote more than one comment. Quotes taken directely from the letters are typed in *"Italics"*. For the protection of the respondents, all respondents are described as "she". Eight categories were coded from the fifteen letters as follows:

- respondents were no longer working in this area;
- the questionnaire was inappropriate;
- the questionnaire was too time consuming;
- respondents had no experience counselling women with HIV/AIDS;
- respondents emphasised individual differences of clients;
- respondents had changed roles within the organisation;
- respondents were working in low prevalence areas of women with HIV/AIDS; and
- respondents had no contact with HIV positive clients.

Table 7.1: Reasons explaining why respondents did not reply to the questionnaire

Reasons explaining why respondents failed to reply	n
Respondents were no longer working in this area	5
The questionnaire was inappropriate	1
The questionnaire was too time consuming	3
Respondents had no experience counselling women with HIV/AIDS	2
Respondents emphasised individual differences of clients	2
Respondents had changed roles within the organisation	2
Respondents were working in low prevalence areas of women with HIV/AIDS	2
Respondents had no contact with HIV positive clients	1

a) Respondents were no longer working in this area

The first reason explaining why workers did not respond to my research may have been the issue of staff turnover. Five workers I wrote to were no longer working in the organisations or had changed positions within the organisations.

b) The questionnaire was inappropriate

One worker complained that the questionnaire was inappropriate, stating in her letter: *"it was not appropriate to the way I work within the clinic".*

c) The questionnaire was too time consuming

Three workers felt that the questionnaire was too time consuming to fill. One worker wrote: *"I started filling in the form but then realised it was completely impractical to finish the task. So many of my responses to questions in regard to timing would amount to sheer guesswork."*

One worker did not only consider my questionnaire as too time consuming but also regarded questionnaires as impersonal and intrusive, saying: *"many people request help from this department for their research when we are trying to see patients and help students under constraints of staff shortages, it is very difficult to respond. I did look at your questionnaire which was too detailed and time consuming to fill - the time I didn't have".* She told me frankly that she had thrown my questionnaires away. She said to me honestly that it was a time of high pressure at work when she received my questionnaires and letters (between Nov. 1995 to Mar. 1996), since she was the only one in charge while other staff were on holiday. She was under pressure from a highly demanding workload and under the strain of a staff shortage. Therefore, she was strongly resistant to participation in the research as such activities would disrupt her workload. However, she did agree to be interviewed.

Another respondent said: *"... I am probably giving you information of limited value. Sadly it's all I can offer with constraints of time. If people really fill this in 20 minutes, I suspect* [that] *you're not getting very reliable data. But in any case even 20-30 minutes is too long for me since I received more than 10 questionnaires from students in the month yours arrived! I could spend my time doing little else!"*

d) Respondents had no experience counselling women with HIV/AIDS

Two organisations wrote that they had not been involved in counselling women with HIV/AIDS. One of them was working mainly with men, saying: "... *I am mostly involved with men. I have supported a number of women directly but, in the main, the work is indirect when it comes to women and children, working through doctors and social workers*".

e) Respondents emphasised individual differences of clients

Two subjects felt that the needs of their clients varied from individual to individual; thus they could not generalise their responses to their clients. One worker said: *"the concerns for every individual client may vary and* [giving] *five overall concerns is a stupid exercise in contemplation. The way to generate this would be to systematically explore a cohort of women and then document the actual concerns...".*

Another felt that the questionnaire was inappropriate for their client group and counselling service. She said in her letter: *"We offer counselling from pre HIV-testing onwards - frequently being involved with some clients until their death; and certainly with most clients and for their family/carers, there is involvement over several years. Individual counselling vary tremendously from client to client in response to needs and could not be allocated into percentages of information/advice giving and client-centred counselling, certainly not in a generalised fashion".*

f) Respondents had changed roles within the organisation

Two respondents explained their reason for not responding to my research was because they had changed their roles in the organisations in which they were working.

g) Respondents were working in low prevalence areas of women with HIV/AIDS

Two organisations expressed the view that the incidence of counselling in women and vertical transmission of HIV/AIDS was extremely limited. One of them expressed their inability to help with the questionnaire and interview, said in a letter: *"We are very sorry we cannot help you with the forms. The reason is that the number of women we have met for whom vertical transmission of HIV is an issue has been too small to be statistically relevant; that is in respect of women with HIV*

positive". Another stated in a letter that they were in a low prevalence area and the incidence of counselling in women and vertical transmission of HIV/AIDS was extremely limited. They enclosed several contact organisations in high prevalence areas to the researcher which brought a positive response as one interview was conducted through this contact.

h) Respondents had no contact with HIV positive clients

One subject had no working experience with HIV positive clients, yet expressed interest on receiving the results of my research, saying: *"I have no contact with HIV positive clients... I am sure if and when we see HIV positive women in the department* [in the future] *the result will be useful"*.

Four additional reasons may explain why workers were resistant to participation in my research:

- workers were suspicious and resistant to the research or hostile to "academics";
- workers were burned out;
- workers were facing too many bereavements; and
- discussions of the low participation rates.

i) Workers were suspicious and resistant to the research

One potential reason why workers did not respond to my research might have rested in their suspicion of and resistance to the research, or hostility to academics (McAvoy & Kaner, 1996). One of the senior HIV/AIDS workers suggested that HIV/AIDS workers were especially hostile to "academics" in general (personal communication, 1995). The suspicion and resistance to my research was most obvious when I made telephone enquiries (1995) to three organisations providing counselling services to women with HIV/AIDS in the UK. After explaining the nature of the research and enquiring the possibility of seeking help from the senior counsellors, two organisations could only provide the name of the counsellor in charge for me to write to, and another organisation would only suggest that I write to the "information department" for help. However, there was no reply.

j) Workers were burned out

As discussed before, it is important to be more aware of the reality that workers are overloaded in their everyday working practice. For example, in this preliminary study, one subject, who was

working in a hospital as a health advisor, would also work anywhere as required by clients. Another subject worked both in the hospital and at her home.

At the beginning of the HIV crisis, there was much talk of 'burn-out' produced by the stress of dealing with infected clients (Bennett *et al*, 1991, Bellani *et al*, 1996, Miller & Gillies, 1996, Nesbitt *et al*, 1996, Visintini *et al*, 1996), although working in other settings, such as with dying children, in an abortion clinic, and with people with mental handicap was probably equally stressful (Sketchley, 1993). As described in one of the interviews by a worker, *"the care for AIDS patients is very complex and very rarely straightforward"* (see Chapter Six: data analysis of interview). Clearly, there are special features of HIV/AIDS that can produce stress which are different from working with other groups of people (see section 3.5).

Workers are not only burned out but also often received very little support from family and friends. Bennett (1995) reported a study on nurses working with AIDS patients who received very little support from family and friends. She suggested that this reflected society's stigmatisation and avoidance of people associated with AIDS. There is a loss of confidence and self-esteem when staff are judged according to their area of work (Bennett, 1995).

k) Workers were facing too many bereavements

Intensified grief and emotional strain caused by bereavement is another reason why workers may have been reluctant to participate in this research. Research into such areas may be threatening because of the levels of stress that it may induce.

The nature of AIDS-related admissions to hospital often involves repeated contact between patients and health care providers. This means that over an extended period of time the health care provider may spend more time with one patient than the average spent with a single patient in many other areas of health care (Bennett, 1995). As AIDS patients return repeatedly for care, staff become closely involved with intimate aspects of their patients' lives. Therefore, staff are involved in the management of psychosocial as well as physical aspects of the patients' care. This is evident in two interviewees' experience of caring for women with HIV/AIDS. As a result, staff become very attached to patients during this process and this serves to intensify feelings of loss when their patients

die. Bennett (1995) identified the concept of "disenfranchised grief" which is often not socially sanctioned. The concept of a disenfranchised griever, described by Bennett, refers to the person who suffers a loss but has little or no opportunity to mourn publicly.

Evidence of "disenfranchised grief" was expressed strongly to me when conversing with one of the senior HIV/AIDS workers (March, 1996). This worker didn't think that she and her colleagues were able to help me with my research by participating in the questionnaire survey or interviews. Yet, she was willing to have an informal conversation with me since she had just had some friends back from visiting Taiwan. Though she gave great compliments to people there, she refused to be tape-recorded. Through indirect evidence in our conversation, I found that resistance to helping my research was based not only on heavy workloads in her organisation, but also on the fact that the workers in her organisation had been facing too many deaths of their clients, friends, or families in a very short period of time. They had attended several funerals within a short time. They felt unable to talk about their work or to help the researcher as a result of intensified grief and emotional strain. Evidence can be found in an interviewee's description in the interview (see Chapter Six: data analysis of interview, p. 134) when care providers (especially those who were HIV positive themselves) withdrew from care and close relationships as a result of facing each stage of the patients' illness and death.

Dixon (1990) gave an example of a worker losing people with AIDS from a close relationship while acting as a care provider for them. In the course of the one-hour interview, the AIDS expert was shaking like a leaf. According to Dixon, the interviewee had no problems thinking, but his nerves were damaged by HIV, hence the uncontrollable shake. "He [the interviewee] was yet another person experiencing multiple losses: his lover had died at home recently, people in the office were ill or had died, and he had been to more than twelve funerals..."(Dixon, 1990:33).

I) Discussions of the low participation rates

Only 12 out of 70 (17%) questionnaires were returned and three interviews were conducted. Unfortunately, none of the respondents required any more questionnaires to pass on to their colleagues. Clearly, the response rates have been higher from other questionnaire surveys in the field of AIDS research than from this research (Table 7.2).

Table 7.2: Questionnaire response rates

Studies	Number of respondents	Returned rates
Bor *et al* (1992)	170 HIV positive patients	89%
de Plessis *et al* (1995)	88 HIV positive patients	81%
Klimes (1989)	256 health professionals	64%
Brown-Peterside (1991)	616 GP trainers and 538 trainees	60%
Galt *et al* (1989)	766 18 and 19-year-olds	58%
Reader *et al* (1988)	214 university students	43%
Coyle & Soodin (1992)	90 HIV counsellors in Health Authority	32%

In comparison with my research, two major factors explain the reasons for low-participation rates. First, those studies in Table 7.2 were all sponsored by organisations. As a full-time Ph.D. student, I am not associated with any HIV/AIDS organisation. I do not have back up from a funding body. The support of an organisation or funding body might have given me more credibility and made negotiations in this difficult subject area a little easier. Lee (1993) emphasises that a sponsor, acting in a bridging or guiding role, serves to facilitate acceptance of the researcher indirectly. Second, most of the researchers in these studies were working in the settings in which they were doing their research. For instance, researchers, such as de Plessis *et al*, Bor *et al*, and Coyle & Soodin were working in the hospitals of their field work settings. Consequently, they gained easier access to the respondents and higher response rates.

7.2.2. Questionnaire

The questionnaire contained two limitations which offer possible reasons why respondents felt overloaded when completing the questionnaire. First, the majority of the questions were open questions. As discussed before, the advantage of using open questions was that the respondents would be able to express their ideas spontaneously. Their views could be used as a basis for the formation of new hypotheses, ideas or awareness. However, the disadvantage was that they might be too time-consuming and difficult to answer. The majority of respondents in this study were working in hospitals or a voluntary HIV agency. A number of studies suggest that health care providers were facing 'burn-out' produced by the stress of dealing with infected clients (Bennett *et al*, 1991, Bellani *et al*, 1996, Miller & Gillies, 1996, Nesbitt *et al*, 1996, Visintini *et al*, 1996), and workers were too busy to complete the questionnaire (McAvoy & Kaner, 1996). This might explain why respondents felt overloaded when completing the questionnaire.

Second, the questionnaire was not piloted and the construction of the questionnaire was problematic. Only five workers passed the questionnaire to their colleagues and three of them returned the questionnaire.

It was not clear, when referring to sections B and C of the questionnaire (Appendix 5.1), whether respondents were expected to indicate their experience in working with women with HIV/AIDS or with people with HIV/AIDS in general. There were two incidences of such a problem.

1. The title of section B is "Experience of working with women with HIV/AIDS" while the two sub-questions in this section were asking the subjects to tick the length and number of HIV positive clients seen.
2. The title for section C is "HIV positive client's concerns". Question C.1 specified "women" clients' concerns, while question C.2 specified "HIV positive clients".

Some workers reported that they could not complete the questions in Section D without reviewing their workload. Question D.1, asking respondents to indicate the number of hours they spent in face to face sessions with their HIV positive clients in a normal working week, was problematic. According to one respondent, the time she spent with HIV positive clients for the first interview would be dramatically different to the ones seen over a period of time. Thus, no generalisation could be made regarding the number of hours she spent with clients in a normal working week.

7.2.3. Interviews

The guarantee of confidentiality was sufficient to reassure interviewees that they had no need to inform the researcher if some of the information given through interviews or informal conversation was 'off the record' (Mertens, 1997). However, careful consideration should be placed on which statements were appropriate as research data. This issue arose particularly with respect to the use of casual and informal conversational material (Jenkins, 1987), since I was sometimes given private opinions in confidence and I was likely to hear a great deal about institutional politics. Although full reporting is necessary, it is essential to safeguard individuals' privacy. The limitation of interviews also rests on the place where interviews were conducted. Two interruptions by other staff during one of the interviews in the respondent's work place could have affected the material that the interviewee shared. The reason for this is that interviewing workers in their work place may produce far more guarded responses than interviewing the same people in the privacy of their homes without the

interruption of other staff or telephone calls (Silverman, 1993).

Conclusions

People with HIV infection have generally been treated in hospitals. In order to meet the demand posed by the AIDS crisis, individuals who were responsible for HIV counselling fulfilled a variety of occupational roles, such as health advisor or specialist nurse. Thus, the role of HIV/AIDS counsellors is diverse. It is not clear how they clarified and managed their multiple responsibilities and duties. A number of factors were derived from this preliminary study.

First, although counselling in medical settings has been largely client-centred, some workers failed to distinguish the differences between information-giving, advice-giving and client-centred counselling. Second, respondents reported that the concerns raised by women with HIV/AIDS were more to do with personal needs rather than medical and practical needs. However, they spent more time in providing information and advice to their clients. The majority of workers spent very little time in client-centred counselling.

The above two points suggest two possibilities. It is possible that:

- there is some confusion about the nature of counselling that workers were providing; or
- workers combined a client-centred approach with a directive approach in their practice.

Third, although the majority of the respondents lacked training in counselling, more than half of them felt that their training prepared them adequately for HIV/AIDS counselling. The degree of effectiveness of their counselling intervention, and the theory and practice adopted for their provision of HIV counselling are unknown.

Therefore, a need for a more general survey of counsellors' perceptions and expectations in working with clients with HIV/AIDS is identified. The above issues all lead to the main study in the present research, which investigates the perceptions of experienced and trainee counsellors with respect to their role with clients with HIV/AIDS. There seems to be remarkably little good quality information on this important area of work and the aim of the second stage of the research is to make some progress in filling this gap.

Part Four:

Main Study

CHAPTER EIGHT: METHODOLOGY

Introduction

In Part Two, the literature review, three major factors are highlighted which suggest the need for investigating the perceptions of trainee and experienced counsellors in working with people with HIV/AIDS.

First, counselling for people with HIV/AIDS has been highlighted as a desirable intervention. Yet, there is neither copyright nor patent on the term 'counselling' and it has been used and misused in all areas of human life. As a result of diversity of opinions and practices, counselling is often interpreted differently by different people. Anyone can easily claim themselves as providing counselling.

Second, the small amount of agreement among the practitioners of HIV/AIDS counselling - about what psychological therapies are appropriate, for what client groups, and at what stage of the disease progression - is highlighted. In responding to the threat of AIDS, the World Health Organisation (WHO, 1990) appears to place high priority on behavioural counselling. Information, education and communication (IEC) are foundations for the prevention and control of HIV infection. Counselling is recognised by the WHO as a vital part of an overall IEC-based

strategy. An assumption in medical settings is common that practitioners should concentrate on non-directive counselling, that is a humanistic approach. It has been argued that the individual does not possess the ability to develop his or her full potential without much assistance. The advantage of directive counselling for people with HIV/AIDS rests on the educational direction in behavioural counselling, in which clients are taught skills that enable them to manage their lives more effectively. Humanistic counselling does not rely on such explicit teaching techniques.

Third, as discussed in Part Two, HIV infection is primarily affected by human behaviour and is preventable to a large extent. However, HIV infections continue to be transmitted at a worrying rate. Counselling for people with or without HIV for behaviour change often has very little success. It has been reported that many people persist in high risk behaviour even after counselling intervention. This raises a number of significant questions about what kinds of counselling are provided, who provides the counselling, what counselling training the counsellors receive, and how much counselling training and what level of expertise is necessary for benefit to occur. As discussed before, many counsellors are ill-prepared to meet the challenge arising from HIV/AIDS or have very little counselling training or no training. Thus, a debate is highlighted about whether anyone can provide HIV/AIDS counselling regardless of the training required, and whether counselling these clients is a specialist activity that is best provided by trained counsellors.

The results of the preliminary study demonstrated that most counselling for women with HIV/AIDS was not carried out by trained counsellors in the organisations contacted. Despite claims in the literature that counsellors have an important part to play in restraining the spread of AIDS, there is no published study that has compared whether experienced counsellors feel better prepared than trainee counsellors to cope with the problems posed by HIV/AIDS. Therefore, the results of the first study and the review of the literature convinced me of a need to seek further information about the perceptions of trainee and experienced counsellors on the issues involved in counselling people with HIV/AIDS.

It was noted in chapter four that there was considerable variation in the training of individuals conducting counselling for people with HIV/AIDS. In other words, counselling was provided by individuals who ranged from unskilled counsellors (who had very little or no training in counselling) to highly skilled counsellors.

Therefore, two major issues were focused on when conducting the main study:

1. the different definitions of counselling adopted by the British Association for Counselling and the World Health Organisation; and
2. whether counselling people with HIV/AIDS requires different skills and training to counselling other groups of clients.

"Research is a most important tool for advancing knowledge, for promoting progress, and for enabling man to relate more effectively to his environment, to accomplish his purposes, and to resolve his conflicts" (Mouly, 1978: 12). The purpose of this study is to investigate the perceptions of trainee and experienced counsellors about their role in working with people with HIV/AIDS. Therefore, the main field work of this research is carried out among experienced counsellors, who have or have not had experience in counselling clients with HIV/AIDS, and trainee counsellors.

The hypothesis is that the role of counsellors in the context of HIV/AIDS will be perceived differently by trainee and experienced counsellors. It is also hypothesised that:

- personal characteristics such as sex, age, year of counselling training, and working experience with clients with HIV/AIDS may predict perceptions of the role of counsellors when working with clients with HIV/AIDS; and
- experienced counsellors feel better prepared than trainee counsellors in working with clients with HIV/AIDS.

The null hypothesis is that there is no significant relationship between the variables.

"Research is best conceived as the process of arriving at dependable solutions to problems through the planned and systematic collection, analysis, and interpretation of data" (Mouly, 1978: 12). This chapter describes the plan and the process of data collection. Chapter nine analyses and interprets the results. The plan and process of data collection for this study are under seven headings:

8.1. Choice of methodology

8.2. The construction of the questionnaire,

8.3. pilot study,

8.4. choice of the sample,

8.5. ethical considerations, and

8.6. procedures.

8.1. Choice of methodology

A questionnaire survey has been chosen as the main instrument for data collection for this study, because it is a quick method to gather data when time is limited (Cohen & Manion, 1994).[35]

8.2. The construction of the questionnaire

The questionnaire was designed to investigate the relationship between:

- the personal characteristics of trainee and experienced counsellors as an independent variable; and
- their perceptions of the role of counselling in working with people with HIV/AIDS as the dependent variable. (see Appendix 8.1)

The questionnaire was also designed to answer the following research questions that derived from the literature review: "How do trainee and experienced counsellors perceive their role in working with people with HIV/AIDS?"

Thus, the design of the questionnaire was based on the aim of this study: to investigate the perceptions of counsellors of their role when counselling people with HIV/AIDS. The questionnaire was designed with the following goals in mind (Mouly, 1978; Ary *et al*, 1990; Oppenheim, 1992):

- each item should be relevant to the subjects;
- each item should be clearly and unambiguously worded;
- each item must make a definite contribution to the overall purpose of the study.

The questionnaire is composed of four sections as follows (Appendix 8.1):

A. personal details;

B. perceptions of the role of counsellor in working with people with HIV/AIDS;

C. experience in working with people with HIV/AIDS; and

D. optional section.

[35] Section 5.1. describes the advantages and disadvantages of questionnaire survey.

A. Personal details

The examination of background information is important to this study because it is hoped to investigate the possibilities of characteristics and factors associated with significant differences in counsellors' perception about their role when working with people with HIV/AIDS. Thus, personal characteristics were divided into background information about the respondents as follows:

Personal details of respondents:

- profession (question A1),
- sex (question A2), and
- age (question A3).

Counselling qualifications of respondents:

- education level: initial and post counselling qualifications (questions A5, A10, & A11), and
- accredited counsellor (question A6).

Counselling experience of respondents:

- length of counselling experience (question A4),
- level of adequacy (question A7) (see next page for details about the Likert scale),
- preferred model and best model for counselling clients with HIV/AIDS (questions A8 & A9), and
- with clients without HIV/AIDS who nevertheless had concerns about it (question B7).

Models of counselling (questions A7, 8, & 9): According to Murdock *et al* (1998), most counsellors can identify a primary theoretical influence even though they might label themselves eclectic. Also, interpretation of any findings associated with this label would be difficult due to the lack of clear definition of the orientation (see chapter 2). Thus, a category for 'eclectic' was not offered. The AIDS epidemic has caused a wave of death in a population unused to facing traumatic loss to such an intense extent. This suggests the need for bereavement counselling for people affected by HIV. It was reported that practice counsellors were more likely to be referred bereaved patients (p. 91). Thus, "bereavement" was included in question A7 as one of the models of counselling.

B. Perceptions of the role of counsellors in working with people with HIV/AIDS

The Likert scale was chosen in this section because it has been one of the most widely and successfully used techniques for measuring attitudes (Ary *et al*, 1990). The Likert scale normally consists of five or seven answer categories (Lovell & Lawson, 1970; Lewin, 1979; Ary *et al*, 1990; Oppenheim, 1992). The use of an odd number of categories permits a neutral middle answer such as "don't know". In order to discourage such neutral answers and avoid such a category (Lewin, 1979), a 4-point Likert Scale was used in this section to apply to any respondent. Thus, the extreme response categories - such as "strongly agree", "agree", "disagree", or "strongly disagree", were used, in order to encourage respondents to report their opinions or attitudes. The statements in this section were arranged in random order so as to avoid any response set on the part of the subjects (Ary *et al*, 1990). The respondents were directed to select the response category that best represented their reaction to each statement (Ary *et al*, 1990).

Question B1. A list of problems frequently associated with HIV/AIDS, which contained 40 items, was derived from the literature review and the preliminary study. Respondents were asked to indicate the usefulness of counselling intervention - "very useful", "useful", "not very useful", or "of very limited use".

Question B2. The role of counsellors was defined by five factors identified in the literature review. They were: advisor, educator, facilitator, information-giver, and objective observer. Respondents were requested to identify the role of counsellors in the context of HIV/AIDS.

Questions B3, 5, and 6. Respondents were required to indicate their values towards the behaviours of people with HIV/AIDS. These were derived from the literature review. A 4-point Likert Scale was applied to question B3 (a, b, & c) for respondents to indicate their level of agreement towards the statements - "strongly agree", "agree", "disagree", or "strongly disagree".

Question B4. Respondents were asked to indicate the degrees of agreement towards 32 items extracted from the literature review and the preliminary study about the aims of counselling when working with people with HIV/AIDS - "strongly agree", "agree", "disagree", or "strongly disagree".

Question B7. As some authors suggest that counsellors trained in the 1990s will be working directly or indirectly with AIDS-related issues, respondents were asked to indicate whether they had any experience counselling people without HIV/AIDS, who nevertheless had concerns about HIV/AIDS.

C. Experience in working with people with HIV/AIDS

Seven questions were extracted from the literature review and the preliminary study concerning counsellors' working experience with clients with HIV/AIDS.

D. Optional section

Oppenheim (1992) suggests that data collection may be regarded as a transaction in which it is usually obvious that the researcher stands to gain, in some sense, and in which the respondent is asked to give time, thought, privacy and effort. In order to promote the return of questionnaires, I offered to mail the results of the study to those who were interested (Mouly, 1978; Ary *et al*, 1990; Oppenheim, 1992). This section would give the respondent the opportunity to indicate whether they would like to receive a brief report on the research.

Respondents were sometimes asked to add their own comments on some questions (questions A9, B7, A8, & C5). It was hoped that, by doing this, respondents would feel more involved and express their opinions more freely and fully.

The questionnaire was inevitably lengthy and consisted of nine pages. I had to balance the pressures of a lengthy questionnaire against the possibility of poor quality, or limited data (Cohen & Manion, 1994). The respondents were asked to complete the questionnaire in their own time so that they were not rushed and the pressure to respond in a particular way would be absent.

8.3. Ethical considerations

Ethical concerns, regarding data collection for this study, include consulting and obtaining permission from the relevant authorities, and respecting respondents' right to privacy and protecting them from any harm.

8.3.1. Obtaining permission from the authorities

One of the ethical principles for the guidance of action researchers, described by Cohen and Manion (1994), is "observe protocol":

> "Take care to ensure that the relevant persons, committees, and authorities have been consulted, informed and that the necessary permission and approval have been obtained".
>
> (Cohen and Manion, 1994: 375)

Initially, my supervisor approached the director of the Centre for Studies in Counselling of a UK university and discussed the possibilities of giving questionnaires to current students and supervisors. A copy of my questionnaire was given to the director for any suggestions and modifications. Then, I approached the director and asked for lists of names of students and supervisors in order to address each respondent by name. For reasons of confidentiality, the director was not willing to provide lists of names. Two things were arranged. First, the director advised me to give the questionnaires for supervisors to the course secretary. The secretary would provide the first name of each supervisor for me to write on the covering letter and the secretary would send them to the supervisors. Second, the course director would write to the tutors and ask for their support and permission for me to give questionnaires to classes of trainees.

8.3.2. Anonymity

There were guarantees of anonymity and confidentiality in this research. The essence of anonymity is that information provided by respondents should in no way reveal their identity (Cohen and Manion, 1994). This is achieved in two ways in this study.

First, no names were to be written on the returned questionnaire,[36] so that respondents might not be identifiable. Therefore, their privacy was guaranteed in this research, no matter how personal or sensitive the information was, and no harm should come to them as a result of their participation in my research (Oppenheim, 1992; Fontana & Frey, 1994).

Second, in order to further safeguard anonymity, the research data was transferred to coded, unnamed data sheets, so that individual responses would not be traceable. Moreover, it is my intention that the raw data on individual questionnaire and interviews will be destroyed following completion of the thesis, so that no respondents are traceable (Cohen & Manion, 1994).

[36] Except for those respondents who were willing to receive a brief report of the findings.

8.4. Pilot study

Although some insight into the study can be obtained from a thorough review of the literature, in most instances it is necessary to conduct a pilot study before the study is finalised (Mouly, 1978; Ary *et al*, 1990; Oppenheim, 1992; Creswell, 1994). The pilot study is important to establish the face validity[37] of an instrument and to improve questions, format, and the scales (Creswell, 1994). It provides an opportunity to assess the appropriateness and practicality of the instruments for data collection (Ary *et al*, 1990). The pilot study was conducted on a smaller sample than that which will be used in the final version of the study (Ary *et al*, 1990; Oppenheim, 1992; Creswell, 1994). Five experienced or trainee counsellors were selected (see Table 8.1) and were given a copy of the questionnaire (Appendix 8.2) and a letter (Appendix 8.3). They were asked to check:

- whether the instructions for the questionnaire were clear;
- whether items were clear and understandable;
- any ambiguities arising from the wording of the questionnaire; and
- the time taken to complete the questionnaire.

Table 8.1: Personal characteristics of respondents

	Number of respondents
Profession	
Counsellor	3
Trainee counsellor	1
Career Adviser/ counsellor	1
Sex	
Female	5
Age	
26-30	1
36-40	2
over 40	2
Total length of counselling experience	
under 3 months	1
7-12 months	1
2-5 years	1
6-10 years	2
Academic and professional qualifications	
Counselling Skills	1
Bereavement counselling	1
Diploma	1
MA	2
Accredited counsellor	
Yes	1
No	4
Working experience with clients with HIV/AIDS	
Yes	2
No	3

[37] Face validity refers to the perception which the people being measured, or the people administering the measures, have of the measure (Clark-Carter, 1997:28).

The respondents answered all questions in sections A and B. Two respondents who had working experience with clients with HIV/AIDS also answered questions in section C. Four out of five reported that the instructions for the questionnaire were clear, all items were clear and understandable, and the wording was clear. One spent 30 minutes, two 35 minutes, and one 55 minutes answering the questionnaire. One respondent completed the questionnaire only but did not measure the time spent answing the questionnaire, and then was away and not able to answer whether the instruction and wording of the questionnaire was clear.

8.5. Choice of the sample

Several authors suggest that counsellors trained in the 1990s will be working directly or indirectly with AIDS-related issues, regardless of their work settings (House *et al*, 1995). However, despite the fact that counsellors may have an important role to play in restraining the spread of AIDS, comparison data on counselling experience were available for trainers and trainees for GPs, but not for experienced and trainee counsellors.

The most common settings for data collection for studying the perceptions of supervisors and trainee counsellors were academic training programmes (Stoltenberg *et al*, 1994). Therefore, the "Centre for Studies in Counselling" in a University in the UK was chosen for this study. Two groups of people were included in the sample.

- Students. The "Centre for Studies in Counselling" provides four courses: "Certificate in Counselling Skills", "Postgraduate Certificate", "Postgraduate Diploma", and "MA". Students attending the "Certificate in Counselling Skills" were excluded in this study as they generally had not had any knowledge or understanding about the theory and practice of counselling. Thus, current students attending "Postgraduate Certificate", "Postgraduate Diploma", and "MA" counselling courses were approached. It was my assumption that students in these three courses already had some understanding of counselling theory and practice.
- Supervisors and experienced counsellors. Experienced counsellors providing supervision for the current (1998) and the previous year's (1997) students attending "Postgraduate Certificate" and "Postgraduate Diploma" counselling courses at the same university were included. Ten other experienced counsellors in the same geographical area were contacted through personal communication.

8.6. Procedures

A three-step procedure was used for the questionnaire survey.

Stage 1: Covering letter

The covering letter is widely believed to be of critical importance to the success of the study (Mouly, 1978; Ary *et al*, 1990). Thus, a covering letter was attached to the questionnaire (Appendix 8.4 or Appendix 8.5). It aimed at explaining the purpose of the study and assuring confidentiality of the answers. The covering letter was also used to thank the respondents for their participation.

Stage 2: Sending questionnaires

Stage 2.1: Sending questionnaires to experienced counsellors

Sixty envelopes, including a copy of the questionnaire (Appendix 8.1), a letter to supervisors (Appendix 8.5), a letter from the course director (Appendix 8.8), and a stamped addressed envelope, were given to the course secretary (20 Nov 1998). A list of the first names of supervisors was given to me to be written on the covering letter addressed to each supervisor. The secretary prepared the name and address labels and sent them to the 60 supervisors. A copy of the questionnaire (Appendix 8.1) and a covering letter (Appendix 8.4) were sent to the ten experienced counsellors. A stamped addressed envelope was also enclosed to facilitate a response.

Stage 2.2: Distributing questionnaires to students

Administration of questionnaires to a number of people at once in a group setting can save the researcher a lot of time (Lovell & Lawson, 1970; Lewin, 1979). This technique is most effective with audiences who are already gathered for some other purpose, such as a class or a meeting (Lewin, 1979). A letter was sent to four tutors (Appendix 8.6), who were responsible for "Postgraduate Certificate", "Postgraduate Diploma", and "MA" counselling courses, and asked for their permission to give my questionnaires to their students.

There were seven classes with ninety-two current students present on the days of my visit (Table 8.2). With the approval of the course director and consent of tutors, a short introduction to the

research was delivered to each class before handing out the questionnaire to students (Appendix 8.7). Each student was given an envelope containing a covering letter (Appendix 8.4), a letter from the course director (Appendix 8.8), a copy of the questionnaire (Appendix 8.1), and a stamped addressed envelope.

Table 8.2: Details of courses, dates of visits and copies of questionnaires given

Courses	Date of courses and the time of my visits	Copies of questionnaires given in classes
Postgraduate Certificate	6:30pm Mon 23 Nov 1998	11
	4:15pm Fri 20 Nov 1998	12
Postgraduate Diploma	5:00pm Tue 24 Nov 1998	12
	9:30am Thurs 19 Nov 1998	12
MA (part-time)	10:00am Wed 25 Nov 1998	14
	6:00pm Mon 30 Nov 1998	6
MA (full-time)	11:50am Tue 24 Nov 1998	25
Total		92

Stage 3: Sending a reminder

Failure to return the questionnaire sometimes stems from a direct rejection of the questionnaire (Mouly, 1978; Oppenheim, 1992), but more frequently it implies nothing more than procrastination (Mouly, 1978). It is also easy for the individual who received a questionnaire to lay it aside and simply forget to complete and return it (Ary *et al*, 1990).

Thus, a second mailing of a reminder letter was sent in January 1999 to urge the sample to complete and send in the questionnaire (Appendix 8.9). It explained that the questionnaire had been sent earlier and that the response was very important to the study. Also, a word of thanks was expressed to those who might have already returned the questionnaire. In sending out follow-up letters, a second copy of the questionnaire (together with a stamped addressed envelope) was included in case the respondent had lost the first (Mouly, 1978; Lewin, 1979; Ary *et al*, 1990; Cohen & Manion, 1994). The respondents were asked not to respond a second time if they had already returned the questionnaire. A letter from my supervisor was also included (Appendix 8.10).

The results are reported in the next chapter in which suitable statistics are selected and discussed.

CHAPTER NINE: RESULTS

Thirty out of 70 (43%) experienced counsellors and 46 out of 92 (50%) students returned the questionnaire. The data were identified by subject number, and thus confidentiality and data security was maintained. For the purpose of entering and analysing the data in an SPSS file (statistical package for the social sciences), each question was identified as a particular variable, and each response was given a numerical code. The codings used are shown in Appendix 9.1 (p. 286). Responses to the 'open' questions were transcribed and are presented in full in Appendix 9.2 (p. 287). The frequencies of each question item were calculated and are presented in Appendix 9.3 (p. 298). Only the more interesting and important results will be presented in the text of this chapter, and as an aid to continuity and for the sake of completeness, other results will be placed in Appendix 9.4 (p. 304).

The results are reported under four headings:

- response rate,
- characteristics of the sample,
- data analysis of combined samples, and
- data analysis - group comparisons.

Finally, the main findings of the empirical study are summarised.

9.1. Response rate

As this appears to be the first study to focus on the self-perceptions of experienced and student counsellors, it is impossible to compare the response rate with previous studies conducted among similar samples. However, compared with other questionnaire surveys in the field of HIV/AIDS reviewed in the literature, the response rates of 43% among experienced counsellors and 50% among students are higher than Reader *et al* (1988, 43%) and Coyle & Soodin's (1992, 32%) studies but lower than Galt *et al* (1989, 58%), Klimes (1989, 64%), Brown-Peterside *et al* (1991, 60%), Bor *et al* (1992, 89%), and de Plessis *et al*'s (1995, 81%) studies.

Five non-respondents wrote to me and explained that the reason for not replying to the questionnaire was due to their lack of working experience with people with HIV/AIDS. Thus, it seems that in some cases of non-response, people excused themselves on the grounds that they did

not know the subject well enough to be able to answer properly. However, it is possible that some of the non-respondents might have been knowledgeable about this subject. One of them who had received training in HIV counselling, but had never had opportunity to work with clients related to HIV/AIDS, wrote:

> *"I started to fill in your questionnaire and then realised that I can be of little help to you as in 30 years as a social worker and counsellor for 19 years I have never had a client requested help with HIV or AIDS related issues. I have had training related to this in case it should ever be needed but I have never used that training directly. Of course that is not to say that none of my clients have had HIV or AIDS - Only that the help I was asked for was not related to these issues directly."*

Moreover, two non-respondents were no longer working in the organisations and one supervisor thought that he was not suitable for my subject group as he was working as a psychologist rather than as a counsellor. Unfortunately, it was impossible to check whether these notions of non-response, based on the grounds of lacking experience with people with HIV/AIDS, staff turnover, and respondents being in other helping professions, were representative of the total of non-respondents.

9.2. Characteristics of the sample

As stated in chapter eight, the hypothesis was that the role of counsellors in the context of HIV/AIDS would be perceived differently by trainee and experienced counsellors. It was also hypothesised that personal characteristics such as sex, age, year of counselling training, and working experience with clients with HIV/AIDS might predict respondents' perceptions of the role of counsellors when working with clients with HIV/AIDS.

Two sets of frequencies were compared in the chi-square test (X^2) (Mouly, 1978; Ary *et al*, 1990) in order to investigate the relationship between these personal characteristics of the respondents. Frequency distributions of one characteristic against another were set up by means of cross tabulations (Ary *et al*, 1990). When both characteristics in the cross tabulation were measured at the nominal level, the chi-square test was used to determine whether a systematic relationship existed between them. In other words, if the respondents' sex, age, year of counselling training, and working experience with clients with HIV/AIDS were similar, then it was expected that a chi-square test would not prove to be significant ($p > .05$)(see section 9.4 data analysis). However, if their personal characteristics were different, it was anticipated that the chi-square would give a significant result ($p < .05$).

The chi-square test requires at least 80% of the cells of a contingency table to contain at least 5 cases (Morrison, 1993). Thus, it was necessary to group "age" into 2 samples (≤ 40 and > 40 years old) because the majority of the respondents were over 40 years old. Respondents' length of counselling experience was also combined into 2 samples (0 to 5+ and 6 to 20+ years). By doing this, it was assured that more than 80% of the cells contained at least 5 cases for the calculation of the chi-square test.

9.2.1. Characteristics of combined samples

Of the 162 questionnaires sent out to experienced and student counsellors, a total of 76 were returned. They consisted of 30 experienced counsellors and 46 students. The respondents were predominately female (84%) and the majority were over 40 years old (72.4%). Their length of counselling experience ranged from none to over 20 years. Only 17% were accredited counsellors and the accrediting organisations were BAC (see details in p. 97), CRUSE and Relate.[38] Twenty percent had working experience with clients with HIV/AIDS; and 43% had counselling experience with clients without HIV/AIDS who nevertheless had concerns about this issue. As the questionnaire was completed anonymously and no previous survey data were available, it was impossible to trace whether these respondents were representative of the entire sample for those five personal characteristics based on sex, age, length of counselling experience, accredited counsellor, and working experience with people with HIV/AIDS.

It is inevitable that those who train in regions with a low prevalence of HIV/AIDS will have less opportunity to gain experience in counselling such clients. Only approximately 20% of the respondents (15/76) had had working experience with clients with HIV/AIDS. Table 9.1 shows that those respondents had significantly more years of counselling experience than respondents without such working experience.

Table 9.1: Working experience with clients with HIV/AIDS and length of counselling experience (n = 76)

Length of counselling	No working experience with HIV/AIDS clients	Working experience with HIV/AIDS clients	Chi-square	p
0-5+ years	35	4	4.545	0.033
6-20+ years	26	11		

[38] BAC (British Association for Counselling), CRUSE (Bereavement counselling) and Relate (Marriage counselling).

In viewing the results for the chi-square in Table 9.2, it can be seen that the results are highly significant. It was anticipated that experienced counsellors were significantly older, and had significantly more years of counselling experience than students. It was also expected that significantly more experienced counsellors were accredited counsellors, had had working experience with clients with HIV/AIDS, and had had experience counselling clients without HIV/AIDS who nevertheless had concerns about HIV/AIDS than students.

Table 9.2: Characteristics of experienced counsellors and students (n = 76)

	Experienced counsellor (n = 30)	Student (n = 46)	Chi-square	p
Sex (n = 75)				
Female	23 (76.7%)	40 (89%)	*	N/A
Male	7 (23.3%)	5 (11%)		
Age				
≤ 40 years old	4 (13.3%)	17 (37%)	5.067	0.024
> 40 years old	26 (86.7%)	29 (63%)		
Length of counselling experience				
0-5+ years	4 (13.3%)	35 (76%)	28.622	0.000
6-20+ years	26 (86.7%)	11 (24%)		
Accredited counsellor				
Yes	9 (30%)	4 (9%)	5.812	0.016
No	21 (70%)	42 (91%)		
Working with clients with HIV/AIDS				
Yes	11 (36.7%)	4 (9%)	8.968	0.003
No	19 (63.3%)	42 (91%)		
**Clients without HIV/AIDS (n = 75)				
Yes	20 (69%)	13 (28%)	11.960	0.001
No	9 (31%)	33 (72%)		

*25% have expected count less than 5

**Counselling experience with clients without HIV/AIDS but having concerns about this

9.2.2. Characteristics of experienced counsellors

The majority of experienced counsellors (86.7%) were over 40 years old, and 76.7% were female (Table 9.2). Thirty-seven percent had working experience with clients with HIV/AIDS and 69% had counselling experience with clients without HIV/AIDS who nevertheless had concerns about this (Table 9.2). Table 9.3 records the professions, length of counselling experience, and the highest qualifications of experienced counsellors. The majority (n = 22) reported their professions as "counsellor", two as "clinical psychologist/psychotherapist", and the rest as "college chaplain", "community psychiatric nurse", "NHS manager", "nurse", "psychologist", and "retired lecturer". Their length of counselling experience ranged from 2 to over 20 years and

nearly half of them were trained at MA/MSc level or higher (Table 9.3). Nine respondents were accredited counsellors by BAC, CRUSE and Relate (Table 9.3).

Table 9.3: Characteristics of experienced counsellors

Length of counselling (n = 30)	n	Profession (n = 30)	n	Highest qualification (n = 30)	n	Accredited organisation (n = 9)	n
2-5 years	4	Counsellor	22	BA/BSc	1	BAC	4
6-10 years	7	Clinical psychologist/ psychotherapist	2	Certificate in counselling skills	2	CRUSE	1
11-15 years	6	College chaplain	1	Postgraduate Certificate	6	Relate	1
16-20 years	6	Community psychiatric nurse	1	Postgraduate Diploma	7	*Not known	3
20+ years	7	NHS manager	1	MA/MSc	13		
		Nurse	1	PhD	1		
		Psychologist	1				
		Retired lecturer	1				

* No information given about accredited organisation

9.2.3. Characteristics of students

Sixty-three percent of students were over 40 years old, 89% were female, (Table 9.2). Nine percent had working experience with clients with HIV/AIDS and 28% had counselling experience with clients without HIV/AIDS who nevertheless had concerns about this (Table 9.2). Table 9.4 shows that 11 students reported their professions as "counsellor", 23 as "trainee counsellor", 9 as "trainee counsellor undertaking placement", and the rest as "drugs worker", "information officer", and "IT manager". In terms of counselling experience, a large majority had between none to 10 years, but 3 had between 16 to 20 years. A number of students were highly experienced, 24% having counselling experience from 6 to over 20 years (Table 9.2). More than half of the students had been trained at least at certificate in counselling skills and postgraduate certificate levels (Table 9.4). Four students were accredited counsellors by BAC and CRUSE (Table 9.4).

Table 9.4: Characteristics of students

Length of counselling (n = 46)	n	Profession (n = 46)	n	Highest qualification (n = 46)	n	Accredited organisation (n = 4)	n
none	7	Counsellor	11	BA/BSc	3	BAC	1
under 3 months	2	Trainee counsellor	23	Certificate in	13	CRUSE	2
3-6 months	1	Trainee counsellor	9	counselling skills		*Not known	1
7-12 months	5	(placement)		Postgraduate Certificate	12		
over 1 year	3	Drugs worker	1	Postgraduate Diploma	8		
2-5 years	17	Information officer	1	MA/MSc	7		
6-10 years	8	IT manager	1				
16-20 years	3						

* No information given about accredited organisation

9.3. Data analysis of combined samples

This section contains descriptive analysis for all respondents under seven headings:

9.3.1. models of counselling

9.3.2. adequacy of counselling

9.3.3. the preferred model and the best model

9.3.4. usefulness of counselling

9.3.5. role of counsellors

9.3.6. values

9.3.7. aims of counselling

9.3.1. Models of counselling

Six respondents reported having received counselling training in one model only, 66 reported having received training in more than one model, and four did not answer this question. The highest number were trained in the person-centred/humanistic model, the second in gestalt therapy, the third in the cognitive behavioural model, the fourth in the psychodynamic model, the fifth in the rational emotive model, and the smallest number in the systemic model (Table 9.5).

From Table 9.5, it can be seen that a high proportion of the respondents had received training in bereavement counselling (n = 56). As the majority of the respondents had received training in the person-centred/humanistic model, it is not surprising to see that nearly all of these respondents who had received training in bereavement counselling had also been trained in the person-centred/ humanistic model (54/56) and 59% were also trained in gestalt therapy (33/56). This suggests that respondents who had received training in bereavement counselling were sympathetic to a humanistic approach to counselling and therapy.

Moreover, it is not surprising to see that nearly all respondents who were trained in the cognitive behavioural (n = 35), rational emotive (n = 21) and psychodynamic (28/29) models were also trained in the person-centred/humanistic models even though each of these models represent distinct approaches towards counselling.

Table 9.5: Models of training in counselling respondents reported they had received

Models of counselling	bereavement (n = 56)	cognitive behavioural (n = 35)	gestalt (n= 41)	person-centred/ humanistic (n = 70)	psycho-dynamic (n = 29)	rational emotive (n = 21)
cognitive behavioural	30					
gestalt	33	25				
person-centred/human	54	35	40			
psychodynamic	26	21	20	28		
rational emotive	18	18	16	21	15	
systemic (n=15)	13	13	12	15	12	13

9.3.2. Adequacy of counselling

Table 9.6 shows that a high proportion of respondents who had received training in the person-centred/humanistic (80%) and psychodynamic (69%) models thought that their training was very adequate or adequate as preparation for working with people with HIV/AIDS. Approximately 40% of respondents who had received training in the cognitive behavioural model and gestalt therapy thought that their training was very adequate or adequate as preparation for working with people with HIV/AIDS. Thirteen percent of respondents who had received training in the the systemic model and only 2% of respondents who had received training in the rational emotive model thought that their training was very adequate or adequate as preparation for working with people with HIV/AIDS.

Table 9.6: Models of counselling respondents perceived as very adequate or adequate

person-centred/humanistic (n = 70)	56 (80%)	gestalt (n = 41)	17 (41%)
psychodynamic (n = 29)	20 (69%)	systemic (n = 15)	2 (13%)
cognitive behavioural (n = 35)	14 (40%)	rational emotive (n = 21)	4 (2%)

9.3.3. The preferred model and the best model

The majority of respondents reported that their preferred model for counselling people with HIV/AIDS was the person-centred/humanistic (78.9%) which was also their view of the best model (81.8%). From Table 9.7, more than 76% of the respondents reported their choices of the preferred model were because the model fitted their personality and/or values, or was based on the counselling training they had received. Approximately 20% to 40% thought that the model

had good research support, or the choice was based on their clinical experience. A small proportion thought that the model was logical, or the choice was based on the orientation of their supervisor.

Table 9.7: Reasons for the choice of the preferred model (n = 76)

the model fits my personality and/or values	61 (80.3%)
the choice of this model is based on the counselling training I have received	58 (76.3%)
the choice of this model is based on my clinical experience	33 (43.4%)
the model has good research support	17 (22.4%)
the model is logical	10 (13.2%)
the choice of this model is based on the orientation of my supervisor	6 (7.9%)

9.3.4. Usefulness of counselling

In viewing Table 9.8, for all respondents, the frequency distributions of results suggest that more than 70% perceived that counselling was "very useful" in dealing with the following 5 problems frequently associated with HIV/AIDS:

> "coping with bereavement(s) (item 5), loss of self-esteem and self-image (item 23), preparation for death of self (partner or child) (item 26), anxiety about death (item 1), and relationship problems (item 27)."

More than 60% perceived that counselling was "very useful" in dealing with the following 4 problems frequently associated with HIV/AIDS:

> "anxiety in general (item 2), suicidal ideations/attempts (item 32), stress (item 31), and feeling of guilt (item 12)."

More than 50% perceived that counselling was "very useful" in dealing with the following 5 problems frequently associated with HIV/AIDS:

> "support in crises (item 33), uncertainty about the future (item 38), HIV antibody testing (positive results) (item 15), family problems (item 11), and depression (item 7)."

More than 40% perceived that counselling was "very useful" in dealing with the following 5 problems frequently associated with HIV/AIDS:

> "difficulty in social relationships (item 8), informing family or sexual partner of HIV status (item 18), reproduction decision (item 28), sexual problems (item 29), and uncertainty about others' reactions (item 36)."

Table 9.8: Problems frequently associated with HIV/AIDS for which respondents felt that counselling was very useful (n = 76)

Items	Number of respondents
(5) Coping with bereavement(s)	59 (78%)
(23) Loss of self-esteem and self-image	58 (76%)
(26) Preparation for death of self (partner or child)	57 (75%)
(1) Anxiety about death	54 (71%)
(27) Relationship problems	54 (71%)
(2) Anxiety in general	50 (66%)
(32) Suicidal ideations/attempts	49 (64%)
(31) Stress	47 (62%)
(12) Feeling of guilt	46 (61%)
(33) Support in crises	43 (57%)
(38) Uncertainty about the future	43 (57%)
(15) HIV antibody testing (positive results)	42 (55%)
(11) Family problems	41 (54%)
(7) Depression	40 (53%)
(8) Difficulty in social relationships	37 (49%)
(18) Informing family or sexual partner of HIV status	35 (46%)
(28) Reproduction decision	34 (45%)
(29) Sexual problems	34 (45%)
(36) Uncertainty about others' reactions	34 (45%)

However, it was surprising that a number of respondents perceived that counselling was "very useful" or "useful" in addressing the following problems which associated with clients' practical needs (Table 9.9):

> "housing (item 16), income support and other financial benefits (item 20), immigration/visas (item 17), 24 hour-7 day a week home care (item 35), payment of bills (item 25), furniture/household appliances (item 13), and transport arrangements (item 34)".

Table 9.9: Practical needs - Problems frequently associated with HIV/AIDS for which respondents felt that counselling was useful (n = 76)

Items	Number of respondents
(16) Housing	15 (19.7%)
(20) Income support and other financial benefits	12 (15.8%)
(17) Immigration/visas	10 (13.2%)
(35) 24 hour-7 day a week home care	8 (10.5%)
(25) Payment of bills	7 (9.2%)
(13) Furniture/household appliances	7 (9.2%)
(34) Transport arrangements	6 (7.9%)

9.3.5. Role of counsellors

For all respondents, the frequency distributions of results suggest that counsellors/ agencies/clients might perceive the role of counsellors differently in the context of HIV/AIDS. Table 9.10 describes results from the highest percentage for each category to the lowest. The majority thought that counsellors would perceive their role as "facilitator"; the funding agency would perceive the counsellor's role as "information-giver"; and clients would perceive the counsellor's role as "advisor". On the other hand, the lowest percentage for each category is as follows: respondents thought that counsellors would perceive their role as "advisor", and the funding agency and clients would perceive the counsellor's role as "objective observer".

Table 9.10: Counsellors' perceptions of how their role is perceived in the context of HIV/AIDS by themselves, their funding agency, and clients (n = 76)

	Number of respondents
(a) Counsellors would perceive their own role as:	
facilitator	67 (88.2%)
information-giver	30 (39.5%)
objective observer	28 (35.6%)
educator	19 (26.8%)
advisor	9 (11.8%)
(b) The funding agency would perceive the counsellor's role as:	
information-giver	49 (64.5%)
advisor	45 (59.2%)
facilitator	42 (55.3%)
educator	39 (51.3%)
objective observer	16 (21.1%)
(c) Clients would perceive the counsellors' role as:	
advisor	53 (69.7%)
information-giver	45 (59.2%)
facilitator	43 (56.6%)
educator	22 (28.9%)
objective observer	20 (26.3%)

9.3.6. Values

The majority of the respondents agreed that counsellors should be willing to disclose their own values in counselling settings (74%, 52/70), but disagreed that counsellors were able to be value-neutral or value-free in the context of HIV/AIDS (80%, 58/73).

In view of the results in Table 9.11, the majority of the respondents (70% to 96%) agreed with the two statements associated with the three main risks of HIV transmission (through unprotected sexual activity, infected blood and vertical transmission) that "counsellors should not overlook the client's responsibility in preventing further infections to others and further deaths" and "counsellors should use all possible means to persuade clients not to place other lives at risk". More than half of the respondents agreed with all the five statements regarding the risk of vertical transmission. Slightly lower percentages of respondents thought that "counsellors would accept the client's right to do so" in relation to the risk of transmission through unprotected sex and infected blood.

Table 9.11: Counsellors' values in relation to the risks of HIV transmission (n = 76)

	unprotected sex	infected blood	vertical transmission
Counsellors should not overlook the client's responsibility in preventing further infections to others and further deaths.	71/74 96%	70/73 96%	68/73 93%
Counsellors should use all possible means to persuade clients not to place other lives at risk.	53/76 70%	60/74 81%	56/73 77%
Counsellors should permit the client to make choices according to the client's own values.	42/75 56%	33/73 45%	47/74 64%
Counsellors should use all possible means to protect the third party.	39/76 51%	49/74 66%	43/73 59%
Counsellors would accept the client's right to do so.	26/76 34%	17/73 23%	42/73 58%

9.3.7. Aims of counselling

In viewing Table 9.12, for all respondents, the frequency distributions of results suggested that more than 80% strongly agreed that counsellors would need to aim at the following 6 items when working with people with HIV/AIDS:

> "listening carefully to clients' responses and helping them to talk through what HIV/AIDS means to them (item 5), being sensitive to client's needs (item 8), being understanding (item 9), being accepting (item 17), being non-judgmental (item 20), and showing empathy (item 31)."

More than 70% strongly agreed that counsellors would need to aim at:

> "being caring" (item 3), "improving clients' self-concept and self-esteem" (item 22), and "being supportive" (item 24).

More than 60% strongly agreed at "being approachable" (item 2); and more than 50% strongly agreed at:

> "having good networks with other professionals" (item 12), "helping clients to decide who else they wished to tell about their HIV status" (item 15) and "helping clients to deal with relationship issues (item 14).

Table 9.12: The aims of counselling with which respondents strongly agreed (n = 76)

Items	Number of respondents
(5) listening carefully to clients' responses and helping them to talk through what HIV/AIDS means to them	68 (89%)
(17) being accepting	65 (86%)
(20) being non-judgmental	65 (86%)
(9) being understanding	64 (84%)
(31) showing empathy	64 (84%)
(8) being sensitive to client's needs	62 (82%)
(24) being supportive	57 (75%)
(3) being caring	54 (71%)
(22) improving clients' self-concept and self-esteem	54 (71%)
(2) being approachable	48 (63%)
(12) having good networks with other professionals	39 (51%)
(15) helping clients to decide who else they wished to tell about their HIV status	39 (51%)
(14) helping clients to deal with relationship issues	38 (50%)

On the other hand, 86% disagreed or strongly disagreed that counsellors would need to aim at "being directive" (item 4) when working with people with HIV/AIDS. This appears to be inconsistent with the results of counsellors' values in relation to the risk of HIV transmission (section 9.3.6) where the majority agreed that "counsellors should use all possible means to persuade clients not to place other lives at risk" (Table 9.11). This will be discussed in the next chapter.

9.4. Data analysis - group comparisons

Data analysis in this section will identify the statistics to be used to compare subject groups or related variables and show whether there is a statistically significant difference between them (see Appendix 9.4, p. 304). The level of significance of < .05 will lead to the rejection of a null hypothesis and suggest a significant difference between the two samples or variables. Yet, this can be a type I error.[39] On the other hand, the level of significance of > .05 will suggest no significant difference between the two samples or variables and therefore the null hypothesis cannot be rejected. Yet, this can be a type II error.[40]

9.4.1. Models of counselling

In order to investigate whether there is a relationship between experienced counsellors and students regarding the models of counselling training they had received, the chi-square test was used (see details in section 9.2). If the models of counselling training that experienced counsellors and students received were similar, it was expected that a chi-square test would not prove to be significant. However, if the models of their counselling training were different, it was anticipated that the chi-square test would give a significant result.

Table 9.13 shows that the level of significance (p) for each model is greater than .05. The results suggest that the null hypothesis is accepted which means that the models of counselling training that experienced counsellors and students received were similar. Does this suggest that respondents' perceptions were similar or different regarding the adequacy of the models of counselling in which they trained as preparation for HIV/AIDS counselling? To investigate this perception it is appropriate to test for a difference in the mean values of the adequacy with which respondents felt that their training had prepared them for working with people with HIV/AIDS. The question is whether differences between the means reach statistical significance (section 9.4.2).

[39] The rejection of a true null hypothesis is labelled a type I error (Ary *et al*, 1990; Breakwell *et al*, 1995).
[40] The retention of a false null hypothesis is labelled a type II error (Ary *et al*, 1990; Breakwell *et al*, 1995).

Table 9.13: Differences between experienced counsellors and students in types of training they had received

Model of counselling		Experienced counsellor	Student	Chi-square	p
Bereavement (n = 56)	No	6	14	1.020	0.313
	Yes	24	32		
Person-centred/Humanistic (n = 70)	No	3	3	*	N/A
	Yes	27	43		
Cognitive behavioural (n = 35)	No	14	27	1.058	0.304
	Yes	16	19		
Gestalt (n = 41)	No	16	19	1.058	0.304
	Yes	14	27		
Psychodynamic (n = 29)	No	17	30	0.563	0.453
	Yes	13	16		
Rational emotive (n = 21)	No	22	33	0.023	0.879
	Yes	8	13		
System (n = 15)	No	23	38	0.450	0.525
	Yes	7	8		

* 50% have expected count less than 5

9.4.2. Adequacy of counselling

On the Likert scale, asking respondents to tick the adequacy with which their training had prepared them for HIV/AIDS counselling, respondents might receive a score from 4 to 1 (4 = very adequate, 3 = adequate, 2 = inadequate, 1 = very inadequate). The t-test was used to examine the difference between the means of two samples (Norusis, 1983). As it was hypothesised that personal characteristics might predict respondents' perceptions, the t-test was used to test for the significant differences between the means of the two samples in the following five categories:

- status: experienced counsellor and student,
- sex: female and male,
- age: 40 and under and over 40 years old (it was necessary to group age into 2 samples because 72.4% of the respondents were over 40 years old),
- length of counselling experience: none to over 5 years and 6 to over 20 years (the reason for grouping respondents' length of counselling experience into 2 samples was due to the similar proportion in each, 51.3% and 48.7%), and
- working experience with clients with HIV/AIDS: yes and no.

If the levels of adequacy with which experienced and student counsellors, females and males, older and younger respondents, respondents with more or fewer years of counselling experience, and respondents with or without working experience with clients with HIV/AIDS perceived that

their training had prepared them for working with people with HIV/AIDS were similar, then it was expected that a t-test would not prove to be significant. However, if their perceptions were different, it was anticipated that the t-test would give a significant result.

In viewing the results for the t-test in Table 9.14, it can be seen that the p values range from 0.056 to 1.000 which means that the results do not reach significance, and the means of the two samples in the five categories are similar regarding the level of adequacy with which respondents felt that their counselling training had prepared them for working with people with HIV/AIDS.

Table 9.14: Level of adequacy with which respondents believed that their training had prepared them to work with clients with HIV/AIDS

	Status		Sex		Age		Counselling experience		Working with clients with HIV/AIDS	
Models	t	p	t	p	t	p	t	p	t	p
Bereavement	0.783	0.437	1.163	0.250	0.443	0.667	0.437	0.664	0.287	0.775
Cognitive Behavioural	1.120	0.271	1.441	0.159	0.764	0.450	1.580	0.124	1.804	0.080
Gestalt	1.098	0.279	0.809	0.424	1.126	0.267	0.872	0.388	0.926	0.360
Person-Centred/ Humanistic	1.175	0.244	0.312	0.756	0.453	0.652	0.872	0.386	0.591	0.556
Psycho-dynamic	1.407	0.171	1.383	0.179	0.494	0.625	1.996	0.056	0.778	0.443
Rational Emotive	1.461	0.160	0.083	0.935	1.430	0.169	0.682	0.504	0.000	1.000
Systemic	1.800	0.095	0.318	0.756	0.052	0.959	1.800	0.095	1.155	0.269
All items	0.852	0.411	0.456	0.657	0.367	0.720	1.020	0.328	1.005	0.335

9.4.3. Reasons for respondents' choice of preferred model of counselling

The chi-square test (see details in section 9.2) was used to investigate the relationship between respondents' personal characteristics and reasons for their preferred model. If the reasons for choice of the preferred model reported by: (a) experienced and student counsellors, (b) females and males, (c) older and younger respondents, (d) respondents with more or fewer years of counselling experience, and (e) respondents with or without working experience with clients with HIV/AIDS, were similar, then it was expected that a chi-square test would not prove to be significant. However, if their reasons for their choice were different, it was anticipated that the chi-square test would give a significant result.

As the models of counselling training that experienced counsellors and students had received and the adequacy with which respondents felt that their counselling training had prepared them for working with people with HIV/AIDS (sections 9.4.1 and 9.4.2) were similar, it was expected that no difference would be found regarding respondents' reasons for the choice of their preferred model. However, the results show that respondents with more years of counselling experience were significantly more likely than respondents with fewer years of counselling experience to think that the reason for this preference was based on their clinical experience ($p < .05$) (Table 9.15). Other results are presented in Appendix 9.4, Table 15.

Table 9.15: Reasons for the choice of the preferred model

Counselling experience		0 to 5+ years	6 to 20+ years	chi-square	p
(5) The choice of this model is based on my clinical experience	Yes	12	21	5.219	**0.022**
	No	27	16		

9.4.4. Usefulness of counselling

Initially, factor analysis was thought to be more appropriate for grouping the 40 items in question B1, which asked respondents to indicate the usefulness of counselling in helping clients to cope with problems frequently associated with HIV/AIDS. However, in order to produce a reliable factor solution, it is advisable that a sample of 200 plus be used where possible (Breakwell *et al* 1995). Smaller samples could be used, but the reliability of the solution might be questionable, and a definite requirement of sample size is that there should be more subjects than variables (Breakwell *et al* 1995).

As the sample in this study was small, all items (except for one) were selected in factor one (containing loadings of .30 or greater). Thus, this analysis was abandoned for further analyses. The grouping of items was therefore based on face validity. Items which shared the same characteristics were combined into the following 6 groups: psychological health, personal concerns, children and family, physical health, life-style arrangements, and social relationship issues (Table 9.16).

Then, in order to determine whether all the items in a group were measuring the same thing, Cronbach's alpha (α), which is also known as an internal-consistency procedure, was used (Ary *et al,* 1990). Cronbach's alpha is suggested when measures have multiple scored items, such as attitude scales (Ary *et al,* 1990) and provides an indication of the internal consistency of the items

(Breakwell *et al,* 1995). The values of Cronbach's alpha were calculated with all the items included in each group and they all had alpha values around 0.7 or greater (Table 9.16).

After this, it was relevant to proceed to the t-test to see whether the difference in the means was significant. On the Likert scale, asking respondents to indicate their perceptions of the level of usefulness that counselling could have in helping clients to cope with the problems frequently associated with HIV/AIDS, respondents might receive a score from 4 to 1 (4 = very useful, 3 = useful, 2 = not very useful, 1 = of very limited use). The t-test was used to examine the difference between the means of the two samples in five categories (status, sex, age, length of counselling experience, and working experience with clients with HIV/AIDS). A number of significant relationships were found in groups 1, 2, 5, and 6.

Table 9.16: Frequent problems associated with HIV/AIDS in six groups

Group 1. Psychological health: (7 items)	**Group 4. Physical health: (8 items)**
(23) Loss of self-esteem and self-image	(22) Loss of health (10) Eating disorders
(32) Suicidal ideations/attempts	(9) Disease progression and loss of control
(2) Anxiety in general	(39) Uncertainty about treatments
(12) Feeling of guilt	(30) Sleep disorders
(31) Stress	(24) Night sitting when ill
(33) Support in crises	(19) Immediate health needs
(7) Depression $\alpha = 0.86$	(6) Coping with physical pains $\alpha = 0.75$
Group 2. Personal concerns: (7 items)	**Group 5. Life-style arrangements: (8 items)**
(5) Coping with bereavement(s)	(16) Housing
(26) Preparation for death of self (partner or child)	(21) Legal problems
	(20) Income support and other financial benefits
(1) Anxiety about death	(13) Furniture/household appliances
(29) Sexual problems	(17) Immigration/visas
(38) Uncertainty about the future	(35) 24 hour-7 day a week home care
(15) HIV antibody testing (positive results)	(25) Payment of bills
(4) Coming off drugs $\alpha = 0.81$	(34) Transport arrangements $\alpha = 0.91$
Group 3. Children and family: (5 items)	**Group 6. Social relationship issues: (5 items)**
(28) Reproduction decision	(27) Relationship problems
(3) Caring for children with or without HIV/AIDS	(8) Difficulty in social relationships
	(36) Uncertainty about others' reactions
(37) Uncertainty about the baby's HIV status	(18) Informing family or sexual partner of HIV status
(40) Welfare of children and family	
(11) Family problems $\alpha = 0.70$	(14) Having a normal life $\alpha = 0.80$

Group 1. Psychological health

Table 9.17 shows a number of significant relationships found among all items and individual items - 32, 31, 2, 7, and 12 but gender differences were not significant in this group. Other results are given in Appendix 9.4, Tables 16-20.

All items Students and respondents who had not had working experience with clients with HIV/AIDS felt that counselling was significantly more useful in dealing with clients' psychological health (8 items) than experienced counsellors and respondents who had such experience ($p < .05$).

Individual items

Students felt that counselling was significantly more useful in dealing with clients' suicidal ideations/attempts (item 32) and stress (item 31) than experienced counsellors ($p < .05$). Older respondents felt that counselling was significantly more useful in dealing with clients' anxiety in general (item 2) than younger respondents ($p < .05$). Respondents who had less counselling experience felt that counselling was significantly more useful in dealing with clients' depression (item 7) than respondents with more counselling experience ($p < .05$). Respondents who had not had working experience with clients with HIV/AIDS felt that counselling was significantly more useful in dealing with clients' feeling of guilt (item 12) than respondents who had such experience ($p < .05$).

Table 9.17: The usefulness of counselling in dealing with clients' psychological health (n = 75)

		n	Mean	t	p
All items	Experienced counsellor	30	3.53	2.833	**0.013**
	Student	45	3.71		
All items	+ no	60	3.67	2.560	**0.023**
	+ yes	15	3.48		
(32) Suicidal ideations/attempts	Experienced counsellor	30	3.47	2.049	**0.044**
	Student	45	3.73		
(31) Stress	Experienced counsellor	30	3.47	2.397	**0.019**
	Student	45	3.73		
(2) Anxiety in general	≤ 40 years old	21	3.43	2.607	**0.011**
	> 40 years old	53	3.75		
(7) Depression	None to over 5 years	39	3.64	2.243	**0.028**
	6 to over 20 years	36	3.36		
(12) Feeling of guilt	+ no working experience	60	3.68	2.565	**0.012**
	+ working experience	15	3.33		

"+" = having or having no working experience with clients with HIV/AIDS

Group 2. Personal concerns

Table 9.18 describes a number of significant relationship found among items 1, 38, 15, and 26. Older respondents felt that counselling was significantly more useful in dealing with clients' anxiety about death (item 1), uncertainty about the future (item 38), and HIV antibody testing

(positive results) (item 15) than younger respondents ($p < .05$). Respondents who had not had working experience with clients with HIV/AIDS felt that counselling was significantly more useful in dealing with clients' preparation for death of themselves (partner or child) (item 26) than respondents who had such experience ($p < .05$). No significant relationships were found among respondents' status, sex, and years of counselling experience in this group. Other results are given in Appendix 9.4, Tables 21-25.

Table 9.18: The usefulness of counselling in dealing with clients' personal concerns (n = 75)

		n	Mean	t	p
(1) Anxiety about death	≤ 40 years old	21	3.43	2.447	**0.017**
	> 40 years old	54	3.78		
(38) Uncertainty about the future	≤ 40 years old	21	3.29	2.157	**0.034**
	> 40 years old	54	3.61		
(15) HIV antibody testing (positive results)	≤ 40 years old	21	3.10	2.160	**0.034**
	> 40 years old	54	3.54		
(26) Preparation for death of self (partner or child)	+ no	60	3.82	2.063	**0.050**
	+ yes	14	3.57		

"+" = having or having no working experience with clients with HIV/AIDS

Group 3. Children and family and Group 4. Physical health

No significant relationships were found in groups 3 and 4 (Appendix 9.4, Tables 26-35).

Group 5. Life-style arrangements

Table 9.19 shows that older respondents felt that counselling was significantly less useful in dealing with clients' life-style arrangements (8 items) than younger respondents ($p < .05$). No significant relationships were found among respondents' status, sex, years of counselling experience and working experience with clients with HIV/AIDS in this group. Other results are given in Appendix 9.4, Tables 36-40.

Table 9.19: The usefulness of counselling in dealing with clients' life-style arrangements (n = 75)

		n	Mean	t	p
All items	≤ 40 years old	21	1.77	2.730	**0.016**
	> 40 years old	54	1.55		

Group 6. Social relationship issues

Table 9.20 shows that respondents who had not had working experience with clients with HIV/AIDS felt that counselling was significantly more useful in dealing with clients' relationship problems (item 27) than respondents who had such experience ($p < .05$). No significant relationships were found among respondents' status, sex, age and working experience with clients with HIV/AIDS in this group. Other results are given in Appendix 9.4, Tables 41-45.

Table 9.20: The usefulness of counselling in dealing with clients' social relationship issues (n = 75)

		Number of respondents	Mean	t	p
(27) Relationship problems	+ no	60	3.78	2.512	**0.014**
	+ yes	15	3.47		

"+" = having or having no working experience with clients with HIV/AIDS

9.4.5. Role of counsellors

The chi-square test (see details in section 9.2) was used to investigate the relationship between respondents' personal characteristics and their perceptions of the role of counsellors in the context of HIV/AIDS. If the choices for the role of counsellors perceived by experienced and student counsellors, females and males, older and younger respondents, respondents with more or fewer years of counselling experience, and respondents with or without working experience with clients with HIV/AIDS were similar, then it was expected that a chi-square test would not prove to be significant. However, if their choices were different, it was anticipated that the chi-square test would give a significant result.

The results show in Table 9.21 that significantly more respondents with more years of counselling experience thought that counsellors would perceive their role as "educator" than respondents with fewer years of counselling experience when working with people with HIV/AIDS ($p < .05$). Significantly more students than experienced counsellors thought that the funding agency would perceive the counsellor's role as "information-giver" when working with people with HIV/AIDS ($p < .05$). Other results are presented in Appendix 9.4, Tables 46-50.

Table 9.21: The role of counsellors in the context of HIV/AIDS (n = 76)

Counsellor's would perceive their own role as:		0 to 5+ years	6 to 20+ years	Chi-square	p
educator	No	34	23	6.338	**0.012**
	Yes	5	14		
The funding agency would perceive the counsellor's role as:		Experienced counsellor	Student		
information-giver	No	15	12	4.533	**0.033**
	Yes	15	34		

9.4.6. Values

On the Likert scale, asking respondents to tick the levels of agreement about the risks of HIV transmissions, respondents might receive a score from 4 to 1 (4 = strongly agree, 3 = agree, 2 = disagree, 1 = strongly disagree). The t-test was used to examine the difference between the means of the two samples in five categories (status, sex, age, length of counselling experience, and working experience with clients with HIV/AIDS).

If the levels of agreement associated with the three main risks of HIV transmission (through unprotected sexual activity, infected blood and vertical transmission) between experienced and student counsellors, females and males, older and younger respondents, respondents with more or fewer years of counselling experience, and respondents with or without working experience with clients with HIV/AIDS were similar, then it is expected that a t-test would not prove to be significant. However, if their perceptions were different, it was anticipated that the t-test would give a significant result.

Table 9.22 shows a number of significant relationships regarding respondents' levels of agreement with the statements associated with the risks of HIV transmissions through infected blood and vertical transmission (other results are presented in Appendix 9.4, Tables 51-65).

risk of HIV transmission through infected blood Students were significantly more likely than experienced counsellors, and respondents who had no working experience with clients with HIV/AIDS were significantly more likely than respondents who had such experience to agree with the statement that the "counsellor should use all possible means to protect the third party" ($p < .05$).

risk of vertical transmission Respondents who had no working experience with clients with HIV/AIDS were significantly more likely than respondents who had such experience to agree that the "counsellor should use all possible means to persuade clients not to place other lives at risk" ($p < .05$).

Table 9.22: Counsellors' values and modes of transmission

		n	Mean	t	p
transmission through blood:					
Counsellor should use all possible means to protect the third party.	Experienced counsellor	29	2.59	2.264	**0.027**
	Student	46	3.04		
Counsellor should use all possible means to protect the third party.	+ no	61	2.98	2.500	**0.015**
	+ yes	14	2.36		
vertical transmission:					
Counsellor should use all possible means to persuade clients not to place other lives at risk.	+ no	59	3.07	2.094	**0.040**
	+ yes	14	2.57		

"+" = having or having no working experience with clients with HIV/AIDS

9.4.7. Aims of counselling

Initially, factor analysis was thought to be more appropriate for grouping items (see details in section 9.4.4) in question B4, which asked respondents to indicate the degrees of agreement about the aims of HIV/AIDS counselling (32 items). As the sample in this study was small, this analysis was abandoned. The grouping of items was therefore based on face validity, and items which shared the same characteristic were combined into 4 groups: counselling methodology, information and prevention, decision making and change, and health care and domestic concerns. Then, the value of Cronbach's alpha (see details in section 9.4.4) was calculated with all the items included in each group and they all had alpha values greater than 0.7 (Table 9.23).

On the Likert scale, asking respondents to tick the levels of agreement for the aims of HIV/AIDS counselling, respondents might receive a score from 4 to 1 (4 = strongly agree, 3 = agree, 2 = disagree, 1 = strongly disagree). The t-test was used to test for the differences in the means of two samples in five categories (status, sex, age, length of counselling experience, and working experience with clients with HIV/AIDS). A number of significant relationships were found in all groups.

Table 9.23: aims of counselling people with HIV/AIDS in 4 groups

Group 1. Counselling methodology (11 items)
(5) listening carefully to clients' responses and helping them to talk through what HIV/AIDS means to them
(31) showing empathy
(20) being non-judgmental
(17) being accepting
(9) being understanding
(8) being sensitive to client's needs
(24) being supportive
(3) being caring
(2) being approachable
(6) being non-directive
(26) being friendly $\alpha = 0.81$
Group 2. Information and prevention (8 items)
(16) helping clients to adopt safer sex practice
(12) having good networks with other professionals
(23) helping clients to reduce other risk factors
(18) providing facts about HIV/AIDS
(7) providing information about infection control issues
(32) providing facts about transmission
(1) making sure that clients know how to reach the counsellor in case of difficulty
(25) preventing the spread of HIV infection and AIDS $\alpha = 0.87$
Group 3. Decision making and change (9 items)
(22) improving clients' self-concept and self-esteem
(15) helping clients to decide who else they wished to tell about their HIV status
(14) helping clients to deal with relationship issues
(29) reducing anxiety and depression
(30) helping clients to inform sexual partners
(13) helping clients to arrange a social support network or to make the best use of them
(10) encouraging clients to prepare for death
(27) promoting behaviour and attitude change
(4) being directive $\alpha = 0.74$
Group 4. Health care and domestic concerns (4 items)
(11) encouraging clients to take positive steps to maintain and improve general health
(21) informing clients about what hospital and voluntary services are available and how to access them
(28) making sure that clients have adequate medical support and services
(19) helping client with practical problems such as housing, welfare benefits, etc. $\alpha = 0.73$

Group 1. Counselling methodology

In viewing Table 9.24, significant relationships are seen among all items in this group, and for individual items - 31, 9, 8, 24, 2, and 6. Other results are given in Appendix 9.4, Tables 66-70. Respondents' difference in years of counselling experience were not significant in this group.

all items Females were significantly more likely than males ($p < .05$) to agree more strongly[41] that counsellors would need to aim at the 11 items (Table 9.23) when working with people with HIV/AIDS.

showing empathy (item 31) Students were significantly more likely than experienced counsellors ($p < .05$), females were significantly more likely than males ($p < .05$), and respondents without working experience with people with HIV/AIDS were significantly more likely than respondents with such experience ($p = .01$) to agree more strongly that counsellors would need to aim at "showing empathy" when working with people with HIV/AIDS.

being understanding (item 9) Students were significantly more likely than experienced counsellors ($p < .05$) and females were significantly more likely than males ($p < .01$) to agree more strongly that counsellors would need to aim at "being understanding" when working with people with HIV/AIDS.

being sensitive to client's needs (item 8) Females were significantly more likely than males and older respondents were significantly more likely than younger ones ($p < .05$) to agree more strongly that counsellors would need to aim at "being sensitive to client's needs" when working with people with HIV/AIDS.

being supportive (item 24), being approachable (item 2)

Females were significantly more likely than males ($p < .01$ and $p < .05$) to agree more strongly that counsellors would need to aim at "being supportive" (item 24) and "being approachable" (item 2) when working with people with HIV/AIDS.

[41] The majority answered "strongly agree" or "agree" for items 31, 9, 8, 24, and 2 (Appendix 9.3, Table 7).

being non-directive (item 6) Older respondents were significantly more likely than younger ones ($p < .01$) to agree that counsellors would need to aim at "being non-directive" when working with people with HIV/AIDS.

Table 9.24: Aims of counselling - counselling methodology (n = 76)

	Sex	n	Mean	t	p
All items	Female	63	3.70	2.215	**0.039**
	Male	12	3.41		
(31) showing empathy	Female	63	3.87	2.531	**0.014**
	Male	12	3.50		
(31) showing empathy	Experienced counsellor	30	3.63	2.782	**0.007**
	Student	46	3.93		
(31) showing empathy	+ no	61	3.89	2.632	**0.010**
	+ yes	15	3.53		
(9) being understanding	Experienced counsellor	30	3.73	2.135	**0.036**
	Student	46	3.91		
(9) being understanding	Female	63	3.90	3.018	**0.003**
	Male	12	3.58		
(8) being sensitive to client's needs	Female	63	3.87	2.497	**0.015**
	Male	12	3.58		
(8) being sensitive to client's needs	≤ 40 years old	21	3.67	2.105	**0.039**
	> 40 years old	55	3.87		
(24) being supportive	Female	63	3.79	3.627	**0.001**
	Male	12	3.17		
(2) being approachable	Female	63	3.68	2.213	**0.030**
	Male	12	3.33		
(6) being non-directive	≤ 40 years old	21	2.86	2.893	**0.005**
	> 40 years old	52	3.35		

Group 2. Information and prevention

Table 9.25 shows that significant relationships were found in all items and individual items - 12, 18, 7, and 32. Other results are given in Appendix 9.4, Tables 71-75. Respondents' difference in age, years of counselling experience and working experience with clients with HIV/AIDS were not significant in this group.

all items Females were significantly more likely than males ($p = .01$) to agree that counsellors would need to aim at the 8 items (Table 9.23) when working with people with HIV/AIDS.

having good networks with other professionals (item 12) Students were significantly more likely than experienced counsellors and females were significantly more likely than males ($p <$

.05) to agree more strongly[42] that counsellors would need to aim at "having good networks with other professionals" when working with people with HIV/AIDS.

providing facts about HIV/AIDS (item 18) Students were significantly more likely than experienced counsellors ($p < .05$) to agree that counsellors would need to aim at "providing facts about HIV/AIDS" when working with people with HIV/AIDS.

providing information about infection control issues (item 7), providing facts about transmission (item 32) Females were significantly more likely than males ($p < .05$) to agree that counsellors would need to aim at the above two issues when working with people with HIV/AIDS.

Table 9.25: Aims of counselling - information and prevention (n = 75)

		n	Mean	t	p
All items	Female	63	3.06	2.772	**0.015**
	Male	12	2.70		
(12) having good networks with other professionals	Experienced counsellor	30	3.27	2.344	**0.022**
	Student	46	3.59		
(12) having good networks with other professionals	Female	63	3.54	2.498	**0.015**
	Male	12	3.08		
(18) providing facts about HIV/AIDS	Experienced counsellor	29	2.72	2.007	**0.049**
	Student	44	3.09		
(7) providing information about infection control issues	Female	60	3.02	2.279	**0.026**
	Male	12	2.50		
(32) providing facts about transmission	Female	59	2.90	2.233	**0.026**
	Male	12	2.33		

Group 3. Decision making and change

In viewing the results in Table 9.26, significant relationships were found among items 22, 15, 14, 29, and 30.[43] Other results are given in Appendix 9.4, Tables 76-80. Respondents' differences in status, years of counselling experience and working experience with clients with HIV/AIDS were not significant in this group.

[42] The majority answered "strongly agree" or "agree" in this item (Appendix 9.3, Table 7).
[43] The majority answered "strongly agree" or "agree" for items 22, 15, 14, and 29 (Appendix 9.3, Table 7).

helping clients to decide who else they wished to tell about their HIV status (item 15), helping clients to deal with relationship issues (item 14) Females were significantly more likely than males and older respondents were significantly more likely than younger ones ($p < .05$) to agree more strongly that counsellors would need to aim at the above two issues when working with people with HIV/AIDS.

improving clients' self-concept and self-esteem (item 22), reducing anxiety and depression (item 29), helping clients to inform sexual partners (item 30) Females were significantly more likely than males ($p < .01$) to agree more strongly that counsellors would need to aim at the above three issues when working with people with HIV/AIDS.

Table 9.26: Aims of counselling - decision making and change (n = 74)

		n	Mean	t	p
(15) helping clients to decide who else they wished to tell about their HIV status	Female	61	3.57	2.394	**0.019**
	Male	12	3.17		
(15) helping clients to decide who else they wished to tell about their HIV status	≤ 40 years old	21	3.29	2.141	**0.036**
	> 40 years old	53	3.58		
(14) helping clients to deal with relationship issues	Female	62	3.56	2.883	**0.005**
	Male	12	3.08		
(14) helping clients to deal with relationship issues	≤ 40 years old	21	3.24	2.435	**0.017**
	> 40 years old	54	3.57		
(22) improving clients' self-concept and self-esteem	Female	62	3.81	4.712	**0.000**
	Male	12	3.17		
(29) reducing anxiety and depression	Female	61	3.54	2.770	**0.007**
	Male	12	3.00		
(30) helping clients to inform sexual partners	Female	60	3.27	2.345	**0.022**
	Male	12	2.75		

Group 4. Health care and domestic concerns

Table 9.27 shows that significant relationships were found among items 11, 21, and 19. Other results are given in Appendix 9.4, Tables 81-85. Respondents' differences in years of counselling experience and working experience with clients with HIV/AIDS were not significant in this group.

encouraging clients to take positive steps to maintain and improve general health (item 11) Females were significantly more likely than males ($p < .05$) to agree that counsellors would need to aim at "encouraging clients to take positive steps to maintain and improve general health" when working with people with HIV/AIDS.

informing clients about what hospital and voluntary services are available and how to access them (item 21) Students were significantly more likely than experienced counsellors ($p < .05$) to agree that counsellors would need to aim at "informing clients about what hospital and voluntary services are available and how to access them" when working with people with HIV/AIDS.

helping client with practical problems such as housing, welfare benefits, etc. (item 19) Experienced counsellors were significantly more likely than students ($p < .01$) and older respondents were significantly more likely than younger ones ($p < .05$) to disagree that counsellors would need to aim at "helping client with practical problems such as housing, welfare benefits, etc.." when working with people with HIV/AIDS.

Table 9.27: Aims of counselling- health care and domestic concerns (n = 74)

		n	Mean	t	p
(11) encouraging clients to take positive steps to maintain and improve general health	Female	61	3.30	2.331	**0.023**
	Male	12	2.75		
(21) informing clients about what hospital and voluntary services are available and how to access them	Experienced counsellor	29	2.66	2.520	**0.014**
	Student	44	3.07		
(19) helping client with practical problems such as housing, welfare benefits, etc.	Experienced counsellor	28	1.68	3.262	**0.002**
	Student	45	2.20		
(19) helping client with practical problems such as housing, welfare benefits, etc.	≤ 40 years old	20	2.30	2.292	**0.025**
	> 40 years old	53	1.89		

9.5. Main findings

Twenty-four main findings are summarised as follows:

1. Thirty out of 70 (43%) experienced counsellors and 46 out of 92 (50%) students returned the questionnaire. Only 17% were accredited counsellors.

2. As anticipated, experienced counsellors were significantly older, had significantly more years of counselling experience, and significantly more experienced counsellors were accredited counsellors, had had working experience with clients with HIV/AIDS, and had had experience counselling clients without HIV/AIDS who nevertheless had concerns about HIV/AIDS than students.

3. One in five respondents had working experience with clients with HIV/AIDS, and two in five had counselling experience with clients without HIV/AIDS who nevertheless had concerns about this issue.

4. A number of supervisors are not necessarily practising counsellors. They reported their various professions as clinical psychologist, psychotherapist, college chaplain, community psychiatric nurse, NHS manager, nurse, psychologist, and retired lecturer.

5. The majority of the respondents had received more than one model of counselling training which suggests that their counselling approach had a strong tendency to be eclectic.

6. The models of counselling training that experienced counsellors and students had received and the adequacy with which they felt that their training had prepared them for working with people with HIV/AIDS were similar. The majority thought that their training in person-centred/humanistic and psychodynamic models were very adequate or adequate but systemic and rational emotive models were perceived as inadequate or very inadequate as preparation for working with people with HIV/AIDS.

7. As the sample in this study was selected from a humanistic counselling training centre, the majority of respondents reported that their preferred model for counselling people with HIV/AIDS was person-centred/humanistic. The majority reported that two major reasons for their choices of the preferred model were firstly the model fitted their personality and/or values, and secondly the choices were based on the counselling training they had received.

8. Less than half of the respondents reported that their choice of the preferred model was based on their clinical experience. However, respondents with more years of counselling experience in this study were significantly more likely than respondents with fewer years of counselling experience to think that the reason for this preference was based on their clinical experience.

9. The majority perceived that counselling was "very useful" in dealing with the following 9 problems frequently associated with HIV/AIDS: *coping with bereavement(s) (item 5), loss of self-esteem and self-image (item 23), preparation for death of self (partner or child) (item 26), anxiety about death (item 1), relationship problems (item 27), anxiety in general (item 2), suicidal ideations/attempts (item 32), stress (item 31), and feeling of guilt (item 12).* On the other hand, the majority perceived, perhaps not surprisingly, that counselling was "of very limited use" in dealing with the following 2 problems frequently associated with HIV/AIDS: *transport arrangements (item 34) and payment of bills (item 25).*

10. A number of significant relationships were found in respondents' perceptions of the level of usefulness that counselling could have in dealing with the problems frequently associated with HIV/AIDS clients. Six groups were derived from the 40 items and all had adequate reliability.

11. Group 1. Psychological health: *loss of self-esteem and self-image (item 23), suicidal ideations/ attempts (item 32), anxiety in general (item 2), feeling of guilt (item 12), stress (item 31), support in crises (item 33), depression (item 7).* Students and respondents without working experience with clients with HIV/AIDS felt that counselling was significantly more useful for all 7 items. Students felt that counselling was significantly more useful for items 32 and 31. Older respondents felt that counselling was significantly more useful for item 2. Respondents with fewer years of counselling experience felt that counselling was significantly more useful for item 7. Respondents without working experience with clients with HIV/AIDS felt that counselling was significantly more useful for item 12.

12. Group 2. Personal concerns: *coping with bereavement(s) (item 5), preparation for death of self (partner or child) (item 26), anxiety about death (item 1), sexual problems (item 29), uncertainty about the future (item 38), HIV antibody testing (positive results) (item 15), coming off drugs (item 4).* Older respondents felt that counselling was significantly more useful for items 1, 38, 15. Respondents without working experience with clients with HIV/AIDS felt that counselling was significantly more useful for item 26.

13. Group 3. Children and family: *reproduction decision (item 28), caring for children with or without HIV/AIDS (item 3), uncertainty about the baby's HIV status (item 37), welfare of children and family*

(item 40), family problems (item 11). There were no significant differences in respondents' perceptions.

14. Group 4. Physical health: *loss of health (item 22), eating disorders (item 10), disease progression and loss of control (item 9), uncertainty about treatments (item 39), sleep disorders (item 30), night sitting when ill (item 24), immediate health needs (item 19), coping with physical pains (item 6).* There were no significant differences in respondents' perceptions.

15. Group 5. Life-style arrangement: *housing (item 16), legal problems (item 21), income support and other financial benefits (item 20), furniture/household appliances (item 13), immigration/visas (item 17), 24 hour-7 day a week home care (item 35), payment of bills (item 25), transport arrangements (item 34).* Older respondents felt that counselling was significantly less useful for all 8 items.

16. Group 6. Social relationship issues: *relationship problems (item 27), difficulty in social relationships (item 8), uncertainty about others' reactions (item 36), informing family or sexual partner of HIV status (item 18), having a normal life (item 14).* Respondents without working experience with clients with HIV/AIDS felt that counselling was significantly more useful for item 27.

17. The majority of the respondents thought that counsellors would perceive their role as "facilitator" when working with people with HIV/AIDS. However, significantly more respondents with more years of counselling experience thought that counsellors would perceive their role as "educator" Significantly more students thought that the funding agency would perceive the counsellor's role as "information-giver". The majority thought that clients would perceive the counsellor's role as "advisor".

18. The majority of the respondents agreed that counsellors should be willing to disclose their own values in counselling settings, but they disagreed that counsellors were able to be value-neutral or value-free in the context of HIV/AIDS. The majority agreed with the two statements associated with the three main risks of HIV transmissions that *"counsellors should not overlook the client's responsibility in preventing further infections to others and further deaths"* and *"counsellors should use all possible means to persuade clients not to place other lives at risk".*

19. The majority strongly agreed that counsellors would need to aim at the following 9 items when working with people with HIV/AIDS: *listening carefully to clients' responses and helping them to talk through what HIV/AIDS means to them (item 5), being sensitive to client's needs (item 8), being understanding (item 9), being accepting (item 17), being non-judgmental (item 20), showing empathy (item 31), being caring" (item 3), improving clients' self-concept and self-esteem (item 22), and*

being supportive (item 24). The majority disagreed or strongly disagreed that counsellors would need to aim at *being directive (item 4).*

20. A number of significant relationships were found in respondents' degrees of agreement about the aims of HIV/AIDS counselling. Four groups were derived from the 32 items and all had adequate reliability.

21. Group 1. Counselling methodology: *listening carefully to clients' responses and helping them to talk through what HIV/AIDS means to them (item 5), showing empathy (item 31), being non-judgmental (item 20), being accepting (item 17), being understanding (item 9), being sensitive to client's needs (item 8), being supportive (item 24), being caring (item 3), being approachable (item 2), being non-directive (item 6), being friendly (item 26).* Females agreed significantly more strongly than males that counsellors would need to aim at all 11 items. Students agreed significantly more strongly for items 31 and 9. Females agreed significantly more strongly than males for items 31, 8, 24 and 2. Older respondents agreed significantly more strongly than younger respondents for items 8 and 6. Respondents without working experience with people with HIV/AIDS agreed significantly more strongly for item 31 than those who had had working experience with these clients.

22. Group 2. Information and prevention: *helping clients to adopt safer sex practice (item 16), having good networks with other professionals (item 12), helping clients to reduce other risk factors (item 23), providing facts about HIV/AIDS (item 18), providing information about infection control issues (item 7), providing facts about transmission (item 32), making sure that clients know how to reach the counsellor in case of difficulty (item 1), preventing the spread of HIV infection and AIDS (item 25).* Females were significantly more likely to agree for all 8 items. Students were significantly more likely to agree for items 12 and 18. Females were significantly more likely to agree for items 12, 7 and 32.

23. Group 3. Decision making and change: *improving clients' self-concept and self-esteem (item 22), helping clients to decide who else they wished to tell about their HIV status (item 15), helping clients to deal with relationship issues (item 14), reducing anxiety and depression (item 29), helping clients to inform sexual partners (item 30), helping clients to arrange a social support network or to make the best use of them (item 13), encouraging clients to prepare for death (item 10), promoting behaviour and attitude change (item 27), being directive (item 4).* Females were significantly more likely to agree for items 15, 14, 22, 29 and 30. Older respondents were significantly more likely to agree for items 15 and 14.

24. Group 4. Health care and domestic concerns: *encouraging clients to take positive steps to maintain and improve general health (11), informing clients about what hospital and voluntary services are available and how to access them (21), making sure that clients have adequate medical support and services (28), helping client with practical problems such as housing, welfare benefits, etc. (19).* Females were significantly more likely to agree for item 11. Students were significantly more likely to agree for item 21. Experienced counsellors and older respondents were significantly more likely to disagree for item 19.

Conclusions

"How do trainee and experienced counsellors perceive their role in working with people with HIV/AIDS?"

Despite the similarity in the models of counselling training they had received and their perceptions of the adequacy with which they felt that training had prepared them for working with people with HIV/AIDS, the results tend to support the hypothesis that the role of counsellors in the context of HIV/AIDS would be perceived differently by trainee and experienced counsellors.

The results also tend to suggest that personal characteristics such as sex, age, year of counselling training, and working experience with clients with HIV/AIDS influenced respondents' perceptions of the role of counsellors when working with clients with HIV/AIDS. Thus, the null hypothesis which predicted that there would be no significant relationships between the variables is rejected.

As the levels of adequacy with which respondents felt that models of counselling training had prepared them for working with people with HIV/AIDS were similar, the hypothesis is therefore rejected which stating that experienced counsellors are better prepared than trainee counsellors in working with such clients.

The next chapter discusses the main findings in relation to the literature review and the preliminary study, and presents the conclusions of the research.

CHAPTER TEN: GENERAL DISCUSSION AND CONCLUSIONS

Introduction

"Learning to measure the previously unmeasured is what science is all about" (Lewin, 1979:9). According to the preliminary study, and Hutton and Wissow (1991), Cantacuzino (1995) and Sobo's (1995) findings, many people who do not know their HIV status have already been infected by the virus. As discussed in the literature review, there is neither vaccine nor effective cure for AIDS, and so counselling consistently is perceived as a desirable intervention when responding to the AIDS epidemic.

However, despite the fact that counsellors may have an important role to play in restraining the spread of AIDS, there is a lack of information about counsellors' perceptions of their role in relation to HIV/AIDS. Comparative data on competence in providing counselling for people with HIV/AIDS were available in the literature for General Practitioner trainers and trainees as HIV/AIDS counselling is often provided by health professionals in medical settings. Yet, there appeared to have been no published study comparing experienced and trainee counsellors, even though experts had suggested that counsellors trained in the 1990s would be working directly or indirectly with AIDS-related issues, regardless of their work settings (House *et al,* 1995).

Therefore, this study attempted to explore perceptions of experienced and trainee counsellors regarding their role in HIV/AIDS counselling. The present study focused on the influence of personal characteristics (status, sex, age, years of counselling experience, and working experience with clients with HIV/AIDS) on the respondents' perceptions of the role of counsellors in the context of HIV/AIDS.

This chapter will start by identifying questionnaire items which respondents found problematic. As mentioned in chapter eight, two major issues were focused on when conducting the main study:

1. the different definitions of counselling adopted by the World Health Organisation (WHO) and the British Association for Counselling (BAC); and
2. whether counselling people with HIV/AIDS requires different skills and training to counselling other groups of clients.

Thus, this chapter discusses the results in relation to the above two issues as follows:

a) directive vs non-directive counselling approaches,

b) approaches to counselling for clients with HIV/AIDS,

c) recommendations for future research, and

d) implications for counsellor training and supervision.

10.1. Questions perceived as problematic

Some of the questionnaire items appeared to have been seen as problematic, either because of comments made about the item, or because of a high rate of non-response, or both. This could indicate that the items were seen as ambiguous or inappropriate in some way, and it seems that even those who answered the questions and did not comment may have shared some of this perception about the item.

Although, according to Oppenheim (1992), ambiguity does not prevent a statement from measuring attitudes satisfactorily, the interpretation of these items must be treated with some caution. For example, the question asking respondents to tick all of their academic and professional qualifications (question A5) caused difficulty. It is not clear whether they were current students undertaking the course which they ticked on the questionnaire or they had already obtained such qualification. For instance, as MA course was the highest training qualification used in this study, it is obvious that students who indicated their highest qualification at an MA level were current MA students. However, it is not known whether students who ticked postgraduate certificate and postgraduate diploma as their highest qualification were current students or had already obtained such qualification. This ambiguity does not affect the measurement of respondents' perceptions of their role in working with clients with HIV/AIDS.

Ten respondents did not answer the question asking them to indicate the best model for working with people with HIV/AIDS (question A9). Table 10.1 shows a number of reasons for this: a) the choice of the model could depend on counsellors' training, personal characteristics, and experience of counselling, b) it was dependent on the clients' agenda, c) respondents were eclectic in their approach, d) respondents worked with one model only, e) respondents had no working

experience with HIV/AIDS clients, f) respondents held no perceptions, so they could not make a judgement.

Table 10.1: Reasons for not answering which model was most appropriate for working with clients with HIV/AIDS

(The respondents might list more than one reason)	Number of respondents
a) Dependent on counsellors' training, personal characteristics, and experience of counselling: (n = 4)	
"Depends on counsellors' training".	1
"Like with all counselling, for me, it is about the 'self' of the counsellor and the relationship between counsellor and client that creates a therapeutic climate. To work with the 'person' of the client not always the issue. Theory allows us to understand the client better; it does not dictate how we should 'be' with the client."	1
"Although I have a specific preference for humanistic models, I feel it is the person of the counsellor which has greatest effect, therefore, the model needs to suit the counsellor rather than the specific client group."	1
"Having experienced counselling oneself is to my mind most important".	1
b) Depends on the client: (n = 5)	
"Would depend on the client's needs; in general, reaching clients at an appropriate emotional/intrapsychic level would be best achieved by psychodynamic and person-centred models."	1
"Don't know. In my experience, clients want different things from counselling."	1
"It would depend on the person and the issues they were bringing."	1
"Depends on the [clients'] issues to be explored".	1
"Clients often prefer to work this way."	1
c) Being Eclectic:	
"I find it difficult to cling to one model permanently! I do not feel one should be model specific in working with HIV/AIDS but be eclectic."	1
d) Working with one model:	
"I'm not sure I can fully answer this as I only work with one model so have little knowledge of other models in this field."	1
e) No working experience with HIV/AIDS clients:	
"I have not worked with people with HIV/AIDS so can not make a judgement."	2
f) No perception: (n = 2)	
"I do not see any one model as being best." "I do not hold any perceptions."	2

Six respondents did not answer the question asking them to indicate whether counsellors should be willing to disclose their own values in counselling settings (question B5). This question seemed to be ambiguous and difficult to answer for some. One stated: "*I don't think this question is as cut and dry as a yes/no answer*". This appears to suggest that those respondents were aware of a range of arguments and thus found it difficult to make a judgement.

Some respondents emphasised the clients' agenda rather than the counsellors' in question B4 which asked them to indicate the levels of agreement about aims of HIV/AIDS counselling. One wrote: "*I may have responded differently if these were the clients' issues and not the*

counsellors' ". This is not surprising considering the client-centred/humanistic approach of the respondents.

Respondents were asked to indicate the perception of the funding agency about the role of counsellors when working with people with HIV/AIDS (question B2). This question seemed to be ambiguous for some. One respondent commented that: "*is this counselling agency, medical agency, or other agency? I answer this as if it is a counselling agency*".

Question B3, asking the respondents to indicate their levels of agreement towards clients' risk behaviours, received a lot of comments. This question seemed difficult to answer, perhaps due to the client-centredness professed by most of the respondents. One respondent stated: "*This depends on the counsellors belief system and philosophical approach to counselling. I would seek to understand the clients' experiences that lead to this behaviour. Then I might have a response to it, depending on the client's experience.*"

Two respondents questioned the statement "counsellors would accept the client's right to do so" in this question (question B3). One wrote: "*right - based on what? law? or my own value system? or ethics*". Another one wrote: "*I'm not sure I'm ready to answer this - I'm open to education around facts and statistics here*" relating to the possibility of vertical transmission. This suggests that the respondent may have had limited knowledge of mother to infant transmission of HIV.

One respondent, commenting on the statement "counsellors should permit the client to make choices according to the client's own values" (question B3), felt helpless about what clients did, stating: "*this is very difficult because ultimately the counsellor has no control over what the client does - can only affirm personal values in congruency*".

With a more extensive pilot study these difficulties could perhaps have been avoided. Nevertheless, they do not invalidate the responses to the questionnaire. These provided interesting information about the perceptions of experienced and student counsellors in relation to their role in HIV/AIDS counselling.

10.2. Directive vs non-directive counselling approaches

The major difference between the definitions of counselling adopted by the WHO and the BAC rests upon the issue of their directive and non-directive counselling approaches (see details in sections 3.2 and 3.3). According to the results recorded in the present study, the majority of the respondents disagreed that counsellors would need to aim at "being directive" (84%), and agreed that counsellors would need to aim at "being non-directive" (82%) when working with people with HIV/AIDS. This appears to be consistent with the views of Bond (1991) and Balmer (1992). However, this is in contrast to the views of Homans and Aggleton (1988), Green (1989), Bor and Miller (1990), WHO (1990), Burnard (1992a), Porche *et al* (1992), Yogev and Connor (1992), Sketchley (1993), and Kiemle (1994), who emphasise the importance of HIV/AIDS counselling and HIV prevention through health education and advice. However, it is also important to note inconsistencies in respondents' replies in the present study (see section 10.2.3).

10.2.1. Preferred model in working with clients with HIV/AIDS

As the sample in this study was selected from a humanistic counselling training centre, the majority reported that their preferred model for counselling people with HIV/AIDS was person-centred/humanistic. It is not surprising to find that the majority believed that counsellors would perceive their role as "facilitator" in the context of HIV/AIDS. This finding is in line with the BAC definition of counselling described in chapter three.

10.2.2. Respondents' personality and values

A very high proportion of respondents in this study (80%) reported that the reason for their choice of their preferred model in working with people with HIV/AIDS was because the model fitted their personality and/or values. These results are different from Norcross and Prochaska's (1983) study, in which clinical psychologists reported deliberate choices of their theoretical orientations, firstly based on their clinical experience, secondly on their values and personal philosophy, and thirdly on their graduate training. The present study suggests that the respondents' ways of conducting counselling were strongly influenced by their personality and values.

A value can be defined as one's standards, beliefs, or judgement of what is valuable or important in life. The question then is whether counsellors should express their own value orientation to their clients. The majority of the respondents agreed with the argument of McGowan and Schmidt (1962) that counsellors should be willing to disclose their own values in counselling settings. It is generally accepted in counselling that counsellors should not express negative value orientation or disapproval of anything the client says or does, has done, or will do. McGowan and Schmidt (1962), Patterson (1980), and Corey (1996) suggest that counsellors are simply not value-neutral, nor are they value-free. However, does this apply to HIV/AIDS counselling? The majority of respondents disagreed that counsellors were able to be value-neutral or value-free in the context of HIV/AIDS.

10.2.3. Inconsistencies in respondents' perceptions

An inconsistency was found from the analysis of the perceptions of the respondents:

a) respondents' perceptions of HIV/AIDS counselling might be more consistent with directive approaches to counselling, but
b) respondents disagreed that counsellors should aim to be directive in the context of HIV/AIDS.

a) perceptions of HIV/AIDS counselling as consistent with directive approaches

It has been argued that HIV infections are primarily affected by human behaviours and it has been suggested that HIV infections are preventable through behaviour change. Should counsellors accept unconditionally the risk behaviours of clients with HIV/AIDS? The respondents did not accept that clients should make decisions according to their own values, and agreed that "counsellors should persuade clients not to place others at risk", HIV prevention was an aim of counselling, and the role of counsellor included that of educator.

Rejection of view that clients should make decisions according to their own values

Students and respondents without working experience with clients with HIV/AIDS were significantly more likely to agree with the statement that the "counsellor should use all possible means to protect the third party" if the counsellor knew that an antibody positive person was going abroad to sell blood, plasma, sperm, or even organs, or was sharing needles with other drug

users. Such a counselling approach appears highly directive. It is consistent with the views of the majority of respondents that counsellors should be willing to disclose their own values in counselling settings and counsellors were not able to be value-neutral or value-free in the context of HIV/AIDS. It suggests that students and respondents without working experience with clients with HIV/AIDS thought that it was the counsellor's duty to protect the third party. They were perhaps likely to be less tolerant than experienced counsellors and respondents with working experience with such clients if they suspected clients of the above behaviours.

Agreement that "counsellors should persuade clients not to place others at risk"

The majority of the respondents agreed with the statement that the "counsellor should use all possible means to persuade clients not to place other lives at risk" in association with the three routes of HIV transmission (through unprotected sexual activity, infected blood and vertical transmission). It is not clear how respondents interpreted the phrase "all possible means" in this statement. Taken literally, it could have included informing a client's sexual partner about his or her HIV positive status against the client's wishes. It is not clear whether respondents would have been willing to go so far, since they might have regarded it as inconsistent with their professional training. This challenges the principle of unconditional acceptance of clients, and the concepts of client-centredness and self-actualisation in humanistic approaches to counselling and therapy.

Respondents without working experience with clients with HIV/AIDS were significantly more likely than respondents with such experience to agree with the statement that "counsellor should use all possible means to persuade clients not to place other lives at risk" if the counsellor knew that an antibody positive woman decided to risk the possibility of vertical transmission and decided to get pregnant. This finding is in accordance with the view of Arras (1990) that women with HIV/AIDS should avoid pregnancy. This suggests that respondents without working experience with clients with HIV/AIDS were more concerned for the welfare of the unborn baby from an HIV positive parent rather than the satisfaction of the parental desire of the mother.

HIV prevention

The majority of the respondents agreed with the statement that the "counsellor should not overlook the client's responsibility in preventing further infections to others and further deaths" in

association with the three routes of HIV transmission (through unprotected sexual activity, infected blood and vertical transmission). This is in accordance with the WHO's definition for HIV counselling in which the prevention of further HIV transmission should be the first aim of counselling. This suggests that respondents' perceptions of HIV counselling might be more consistent with directive approaches.

Students were significantly more likely than experienced counsellors to agree that counsellors would need to aim at "providing facts about HIV/AIDS" which appears to be in line with the claims of HIV counsellors in the preliminary study who placed emphasis on giving information to clients to avoid them going away feeling disappointed. Moreover, females were significantly more likely than males to agree on all items associated with "information and prevention" as the aims of HIV/AIDS counselling.[44] This finding appears to suggest that females were more aware of and agreed more with the WHO's definition of HIV counselling which highlights the aims of counselling that are primarily about prevention and more consistent with directive approaches to counselling. One could speculate whether female counsellors were more likely to empathise with a female need for "information and prevention" in reducing infection by male partners. This is evident in the interviews conducted for the preliminary study that the three female HIV counsellors all placed emphases on their female clients' need for "information and prevention".

The role of counsellors as educator

Only a few respondents described their role as "educator" (26.8%). However, significantly more respondents with 6-20+ years of counselling experience than respondents with fewer years of counselling experience thought that counsellors would perceive their role as "educator" when working with people with HIV/AIDS. This suggests a possibility that this group of respondents had recognised the importance of educational components in HIV/AIDS counselling. They appeared closer to agreement with the WHO's definition of HIV/AIDS counselling which is more clearly consistent with directive approaches. It seems that counsellors with more years of experience had become more aware of the educational aspects of counselling in relation to HIV/AIDS, and perhaps more cautious about the adequacy of counselling itself.

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[44] Information and prevention contains 8 items: helping clients to adopt safer sex practice (item 16), having good networks with other professionals (item 12), helping clients to reduce other risk factors (item 23), providing facts about HIV/AIDS (item 18), providing information about infection control issues (item 7), providing facts about transmission (item 32), making sure that clients know how to reach the counsellor in case of difficulty (item 1), preventing the spread of HIV infection and AIDS (item 25).

b) disagreement that counsellors should aim to be directive

However, the respondents were not prepared to be directive in their counselling approach in working with clients with HIV/AIDS. The discussion above was based on the respondents' perceptions of HIV/AIDS counselling being more consistent with directive approaches, but is inconsistent with the evidence that the majority disagreed that counsellors would need to aim at "being directive" when working with clients with HIV/AIDS. This suggests that respondents might find it difficult to cope with tensions between their personal beliefs/values and their preferred approach to counselling. Therefore, the next section discusses whether counselling for people with HIV/AIDS requires different skills and training to counselling other groups of clients.

10.3. Approaches to counselling for clients with HIV/AIDS

According to Miller and Bor (1988), and Green and McCreaner (1989), individuals would require a considerable amount of training and/or experience in a broad range of areas if they were to feel comfortable in fulfilling the role of HIV counsellor as envisaged in the WHO's definition. The question here is whether counselling people with HIV/AIDS requires different skills and training to counselling other groups of clients. This section discusses evidence derived from the main study on the perceptions of experienced and student counsellors on the above issue.

10.3.1. Evidence that HIV/AIDS counselling does not require different approaches to counselling other groups of clients

The following issues suggest that HIV/AIDS counselling does not require different approaches to counselling other groups of clients:

a) respondents perceived that their training in person-centred/humanistic was adequate

b) respondents perceived that their training in psychodynamic model was adequate

c) respondents perceived that their training in bereavement counselling was adequate

d) the choice of the preferred model was based on the respondents' clinical experience

e) respondents' belief that counselling was useful in dealing with HIV/AIDS clients' problems

a) respondents' perception of their training in person-centred/humanistic model

The sample in this study was selected from a "Centre for Studies in Counselling" which was predominately humanistic in orientation. It is therefore not surprising to see that nearly all respondents had received training in this model. The majority of the respondents (76%) reported that the reasons for their choice of a preferred model were based on the counselling training they had received. A high proportion thought that their training in this model was very adequate or adequate as preparation for working with people with HIV/AIDS. Whether this implies that respondents also felt that their training in this model was very adequate for working with people without HIV/AIDS was unknown, as the adequacy for counselling clients without HIV/AIDS was not measured in this study. However, if this is the case, it may suggest that respondents believed that the skills and training required for counselling people with HIV/AIDS were not different from counselling other groups of clients. The results here support Bond's report (1991) that HIV counselling is not a different kind of counselling and is in contradiction to the discussion in section 3.5.2 that HIV counselling differs from counselling people without HIV/AIDS.

b) respondents' perception of their training in psychodynamic model

Thirty-eight percent of the respondents had received training in a psychodynamic model as well as a person-centred/humanistic model. A high proportion thought that their training in the psychodynamic model was very adequate or adequate as preparation for working with people with HIV/AIDS. This is in contrast to Sikkema & Bissett's (1997) view that such a model offered a particularly poor fit when applied to HIV/AIDS counselling. This suggests that respondents perceived that the skills and training required for counselling people with HIV/AIDS were similar to counselling other groups of clients.

c) respondents' perception of their training in bereavement counselling

As mentioned in chapter three, the AIDS epidemic has caused a wave of deaths in a population unused to facing traumatic loss to such an intense extent; and the bereavements are often multiple and occur in a brief period of time (see chapter 3.5.2c). The provision of bereavement counselling for people infected by HIV becomes crucial. It was therefore important to investigate

respondents' perception of the adequacy of bereavement counselling and whether counsellors who were trained in bereavement counselling were also trained in other models of counselling. Of the 56 respondents who were trained in bereavement counselling, the majority had also received training in the person-centred/humanistic model and gestalt therapy; half of them had received training in the cognitive behaviour model and psychodynamic model, and about one-third in the rational emotive and systemic models. The majority of the respondents who were trained in bereavement counselling felt that such training was very adequate or adequate as preparation for working with people with HIV/AIDS. This suggests that respondents felt well prepared to handle the complicated issues arising from bereavements related to HIV/AIDS (see section 3.5.2).

The results which suggested that the respondents perceived that their training in person-centred/humanistic and psychodynamic models, and bereavement counselling were adequate as preparation for working with such clients could be interpreted as encouraging. They suggest that respondents felt themselves to have been well prepared for working with people with HIV/AIDS. However, this could also suggest that respondents perceived that the skills and training required for counselling people with HIV/AIDS were similar to counselling other groups of clients. Thus, it is possible to suggest that they felt well prepared. Yet, these findings may also reflect respondents' limited awareness of the needs of people with HIV/AIDS. The apparent failure of many respondents to recognise the implicit contradiction between being non-directive and taking all possible measures to persuade clients not to place others at risk could be seen as evidence to support this view.

d) The choice of a preferred model based on the respondents' clinical experience

Only 43% of the respondents in this study reported that their choice of a preferred model for counselling people with HIV/AIDS was based on their clinical experience, which appears to be in contrast to Norcross and Prochaska's (1983) finding when clinical experience was the most influential variable in selecting an orientation for clinical psychologists. However, one significant relationship was found from the analysis of respondents' reasons for adopting a preferred counselling model in working with people with HIV/AIDS. Respondents with 6-20+ years of counselling experience were significantly more likely than respondents with fewer years of counselling experience to think that the reason for this preference was based on their clinical experience. This finding needs to be interpreted cautiously. One needs to bear in mind that only

half of the respondents in this group had working experience with people with HIV/AIDS. It is possible that the reason for this preference referred to respondents' clinical experience with both groups of clients with and without HIV/AIDS. This suggests that respondents' perceptions of the skills and training required for counselling people with HIV/AIDS were not very different from counselling other groups of clients.

e) Respondents' belief that counselling was useful in dealing with HIV/AIDS clients' problems

Respondents' belief that counselling was useful in dealing with the following problems frequently associated with HIV/AIDS appeared to suggest that counselling for people with HIV/AIDS did not require different skills and training to counselling other groups of clients.

suicidal ideations/ attempts and stress

Suicidal ideations/attempts and stress are problems often experienced by people with HIV/AIDS (Boland & Harris, 1992; Campbell, 1995; Catalan & Pugh, 1995; Miller, 1995; Sherr, 1995bd; Starace, 1995); counselling for such issues is difficult and problematic, and some authors have urged specialised counselling training for such issues. However, a high proportion of respondents believed that counselling was useful in dealing with suicidal ideations/attempts and stress of HIV/AIDS clients. As the majority reported their choice of a preferred model for working with clients with HIV/AIDS was client-centred/humanistic model, this suggests that they perceived that this model was useful in dealing with the two problems above. The impression here is that respondents perceived that counselling for people with HIV/AIDS did not require different skills and training to counselling other groups of clients. Moreover, students felt that counselling was significantly more useful than experienced counsellors in dealing with these two items. This may suggest that students were too optimistic about what counselling could offer.

depression

Chapter one discussed the likelihood that physical illness can also lead to psychiatric morbidity, especially depression. Many patients attending AIDS clinics were receiving psychiatric treatment, the main diagnosis being depression (Pugh, 1995). The majority of the respondents felt that counselling was useful in dealing with HIV/AIDS clients' depression. Bearing in mind that the majority were trained in the humanistic counselling approach, this finding appears to suggest that respondents might perceive that counselling for clients with HIV/AIDS did not require different

skills and training to counselling other groups of clients. Respondents with fewer years of counselling experience felt that counselling was significantly more useful in dealing with this issue. This may suggest that respondents with fewer years of counselling experience were too optimistic about what counselling could offer to this group of clients. It is possible that this could be attributed to their relative lack of knowledge of the benefits of medical intervention.

physical health

As the respondents in the present study were trained predominantly in the humanistic approach, it was anticipated that respondents with working experience with clients with HIV/AIDS would perceive that counselling for clients' problems related to physical health was less useful. However, it was surprising that the majority felt that counselling was very useful or useful in dealing with clients' problems associated with "loss of health" (83%), "disease progression and loss of control" (80%), and "uncertainty about treatments" (64%). This might suggest that respondents might perceive that counselling was useful in helping clients to come to terms with the emotional distress associated with the above problems. This suggests that respondents might perceive that counselling for people with HIV/AIDS did not require different approaches than a humanistic model.

10.3.2. Evidence that HIV/AIDS counselling requires different approaches to counselling other groups of clients

However, inconsistent results were found and are discussed in this section which suggest that HIV/AIDS counselling does require different approaches to counselling other groups of clients:

a) the role of counsellors as advisor and information-giver, and

b) issues related to cognitive behavioural approaches.

a) the role of counsellors as advisor and information-giver

Respondents tended to think that clients and the funding agency would perceive their role differently in the context of HIV/AIDS. This reveals the awareness of respondents of conflicting opinions on the role of HIV counsellors in two ways. First, nearly two-thirds of respondents considered that clients and the funding agency would perceive their role as "advisor" or

"information-giver". This finding may suggest that respondents perceived that the expectations held by clients and the funding agency on the role of HIV counsellors were not in accordance with the aim of a humanistic approach. Second, it was interesting to find that significantly more students than experienced counsellors thought that the funding agency would perceive the counsellor's role as "information-giver". This appears to suggest that more students perceived that the funding agency would place emphasis on the role of HIV counsellors as providing information instead of psychological and emotional support.

The above two findings support the findings in the preliminary study that workers who were responsible for HIV counselling had to satisfy the demands of their agencies and clients. Thus, they had to spend time in providing information and advice to the clients in their actual practice even though they reported that the concerns raised by women with HIV/AIDS were more on personal needs (rather than medical and practical needs) which would require more psychological support.

Furthermore, it is possible that respondents were aware that, in the context of HIV/AIDS, clients and the funding agency would expect them to provide advice and information which tended to be more consistent with a behavioural approach to counselling, and parallel to the WHO's definition of HIV counselling. How would they fulfil the role of HIV counsellor in these circumstances? Does this suggest that clients and the funding agencies assumed that any counsellor was competent to provide advice and information in relation to HIV/AIDS?

b) issues related to cognitive behavioural approaches

Lack of agreement was found among respondents trained in the cognitive behavioural model (n = 35). Slightly higher percentages of experienced counsellors (more than 50%) than students (26%) thought that their training in the cognitive behavioural model was very adequate or adequate as preparation for working with people with HIV/AIDS. This may suggest that experienced counsellors who had training in this model felt slightly better prepared than students trained in the same model. This group of respondents who perceived a cognitive behavioural model as being adequate was in line with Sikkema & Bissett's (1997) suggestion that this approach addressed nearly all aspects of HIV counselling, hence was more appropriate than other approaches. This suggests that the respondents acknowledged that counselling for people with HIV/AIDS required

different counselling approaches than a humanistic model; hence, such counselling did require different skills and training to counselling other groups of clients.

Respondents agreed that HIV counselling had aims which might be more consistent with a cognitive behavioural approach than with a humanistic model. It was surprising that the majority of the respondents who were predominately trained in the humanistic approaches agreed that counsellors should aim at "helping clients to adopt safer sex practice" and "helping clients to reduce other risk factors" which were more consistent with a cognitive behavioural approach. Moreover, it was surprising that high proportions perceived that counselling for clients' problems frequently associated with "eating disorders" (86%), "sleep disorders" (72%), and "coping with physical pains" (58%) was very useful or useful since they would be likely to benefit from cognitive behavioural interventions (Sikkema & Bissett, 1997). Five respondents did not answer the levels of agreement about whether counsellors should aim at "helping clients to adopt safer sex practice". This probably suggests that respondents had very limited knowledge and awareness about this issue. The above findings may imply that they may not have thought rigorously about the relevance of their training and of their preferred orientation for working with clients with HIV/AIDS.

Therefore, it is evident that the respondents perceived that counselling for clients with HIV/AIDS did not require different approaches to counselling other groups of clients. However, this is inconsistent with the evidence found in the respondents' perceptions that counselling for clients with HIV/AIDS did require different approaches to counselling other groups of clients. It is possible that respondents might simply have not thought rigorously about the relevance of their training and of their preferred orientation for working with clients with HIV/AIDS.

10.4. Recommendations for future research

Three major areas are recommended for future research into the field of HIV/AIDS counselling:

1. replication of the study with samples trained principally in different counselling approaches;
2. examination of changes over time in counsellors' perceptions in working with clients with HIV/AIDS; and
3. investigation of counsellors' anxieties/tensions in preparation for working with clients with HIV/AIDS.

10.4.1. Replication of the study

Some of the questionnaire items received only a very limited range of responses or provoked the same response from a large majority of respondents (Appendix 9.3, Frequency Tables 2-8). Two possible reasons might explain this agreement between respondents. First, although respondents were asked to complete the questionnaire in their own time so that they were not rushed or pressured to respond in a particular way, "the problem of bias cannot be eliminated from scientific work" (Lewin, 1979:10). Respondents' answers might have been biased because of social pressure to provide answers they believed to be socially appropriate (Rugg *et al*, 1991).

The second reason for this is possibly due to the fact that no significant differences were found between the models of counselling training experienced counsellors and students had received (Table 9.13). It is evident that these two samples both shared a similar training background. Thus, it is possible that for these two particular samples, the construct itself would not discriminate between the respondents, even if it was well measured. In this case the lack of range in responses could reasonably be interpreted as homogeneity of the sample - everyone gave the same response because they were all essentially trained in similar approaches.

The violation of the assumption of normality in this study does not nullify the validity of the t-test. Although normality[45] was assumed in the mathematical derivation of the t-test (i.e. unless the observations were normally distributed the t-test would not be a legitimate statistical option), in recent decades subsequent research has revealed that "the violation of the assumption of normality does not nullify the validity of the t-test" (Hopkins *et al*, 1996:202). According to Hopkins *et al*, the condition of normality can be largely disregarded as a prerequisite for using the two-tail t-test. The t-test is "robust with respect to failure to meet the normality assumption" (Hopkins *et al*, 1996:204).

Items grouped in questions asking respondents to indicate the usefulness of counselling (question B1) and the degree of agreements regarding the aims of HIV/AIDS counselling (question B4) all had alpha values greater than 0.7 which demonstrated a high reliability coefficient (Tables 9.16 and 9.23). Breakwell *et al* (1995) suggest that the higher the correlation between the items the greater the internal consistency. According to Ary *et al* (1990), if the results are to be used as a basis for making important decisions about individuals, only instruments with the highest reliability are acceptable. However, if the results are to be used for making a decision about a

[45] normality = the observations both in population 1 and in population 2, are normally distributed

group or even for research purposes, a lower reliability coefficient (in the range of .30 to .50) might be acceptable (Ary *et al,* 1990:281).

The purposive sample in this study may not be representative of the population of experienced and trainee counsellors. Therefore, no generalisations should be made on the basis of the returned questionnaires. As "the proper subject matter of psychology is not settled once and for all time: it is open to endless revision" (Lewin, 1979:9), the reported results await replication in two areas. First, as some of the items provoked the same response from a large majority of respondents, it is doubtful whether using samples trained in different approaches would produce the same high reliability coefficient. Thus, the replication of the study with samples trained principally in different counselling approaches is strongly recommended. Second, it appears that respondents in counselling training programmes had not received systematic training in issues relating to HIV/AIDS or clinical experience with such clients. The present study was carried out in a fairly low HIV prevalence area, and counsellors may therefore have had limited knowledge and low awareness of the needs of people with HIV/AIDS. Only one in five respondents in the main study had working experience with clients with HIV/AIDS; and two in five had counselling experience with clients without HIV/AIDS who nevertheless had concerns about this issue. Thus, it might be possible to replicate the study with samples trained in different geographical areas (i.e. high HIV/AIDS prevalence areas). If the replications were to confirm the original findings, then I will be able to have considerable confidence in the generalisation of the results.

10.4.2. Examination of changes over time in counsellors' perceptions

Owning to the inconsistency noted above, it was suggested that respondents might not have thought rigorously about the relevance of their training and of their preferred orientation for working with clients with HIV/AIDS. This study only investigated experienced and trainee counsellors' self-perceptions and did not focus on the outcome of their actual working experience with clients with HIV/AIDS. Several respondents stressed that their perceptions reported in the questionnaire were generally based on their working experience with clients without HIV/AIDS. They stated that their perceptions might be different once they had had working experience with clients with HIV/AIDS. No studies appear to have examined change over time in counsellors' perceptions. HIV/AIDS counselling research would benefit from longitudinal research on the examination of changes in counsellors' perceptions over time, even though this kind of research is difficult and expensive to conduct.

10.4.3. Investigation of counsellors' anxieties/tensions

Health professionals' fears and anxieties about working with people with HIV/AIDS has been examined (section 4.4.1) but very little information is available about such anxiety among counsellors. Findings suggest that the longer and presumably more in-depth are the courses on general counselling and HIV counselling that an individual attends, the less likely it is that the person will find the provision of post-test HIV counselling stressful (Coyle & Soodin, 1992). The present study has not explored whether respondents feel comfortable interacting with clients with HIV/AIDS, and has ignored the measurements of anxiety counsellors inevitably face in preparation for working with such clients. It is suggested that the inconsistency in the responses might be due to respondents' difficulty in coping with tensions between their personal beliefs/values and their preferred approach to counselling. HIV/AIDS counselling research would also benefit from investigating whether students have higher levels of anxiety than experienced counsellors in preparation for working with this group of clients and whether anxiety can be reduced through extensive AIDS education, workshops or counselling training.

10.5. Implications for counsellor training and supervision

The above discussions all serve as basis for the discussion of the implications of the present study for counsellor training and supervision. It was argued before that the inconsistent results of respondents' perception in this study suggest that they:

a) may have somewhat limited knowledge and awareness about issues related to people with HIV/AIDS,
b) may not have thought rigorously about the relevance of their training and of their preferred orientation for working with this group of clients, and
c) may find it difficult to cope with tension between their personal beliefs/values and their preferred approach to counselling.

Four implications are raised for discussion:

1. implication for conflicting values between counsellors and clients related to the risks of HIV transmission;
2. implication for the role of HIV/AIDS counsellors as information-giver ;
3. implication for HIV/AIDS clients' problems that might benefit more from cognitive behavioural interventions; and
4. implication for counselling for suicide and bereavement of clients with HIV/AIDS.

10.5.1. implication for conflicting values between counsellors and clients related to the risks of HIV transmission

The present study suggests that counsellors need to look closely at the conflicts between their own values and HIV/AIDS clients' values. Three major areas of such conflicts were:

> "If the counsellor knows that an antibody positive person continues unprotected sexual activity with an unsuspecting partner.
> If the counsellor knows that an antibody positive person goes abroad to sell blood, plasma, sperm, or even organs; or shares needles with other drug users.
> If the counsellor knows that an antibody positive woman decides to risk the possibility of vertical transmission and decides to get pregnant - even after having delivered an infected child." (Appendix 8.1, question B3 a, b, c)

It is evident from the literature review that many people are infected by partners who did not know their HIV status or who kept their status in secret (Hutton & Wissow, 1991; Cantacuzino, 1995; Sobo, 1995; Fennema *et al*, 1998). Although the number of people with HIV/AIDS who sell blood, plasma, sperm, or even organs abroad is unknown, it is not impractical to bear in mind such issues. It was reported in the literature review that several infants in the Netherlands were infected by HIV through infected blood from a single donation of blood of a healthy adult found to be HIV positive (Peckham & Newell, 1990), and many children had acquired HIV infection in the medical setting via infected blood in Romania (Hersh *et al*, 1991). Furthermore, an increasing number of HIV infections among intravenous drug users was reported in the literature review (Dixon, 1990; Bauman, 1995). Although there appears to be no published study on the proportion of women with HIV/AIDS who have risked second or third pregnancy after having delivered an infected child, it is evident in the literature review that the number of paediatric AIDS cases is increasing and many seropositive women have continued their pregnancy and have often had subsequent pregnancies (Sherr, 1991ab; Boland & Harris, 1992; Sanford & Vosmek, 1993).

As discussed before, the majority of the respondents agreed that: a) the "counsellor should use all possible means to persuade clients not to place other lives at risk" and b) the "counsellor should not overlook the client's responsibility in preventing further infections to others and further deaths" in association with the three routes of HIV transmission as above. However, a contradiction was noted that the respondents were not prepared to be directive in their counselling approach for working with clients with HIV/AIDS. Inconsistencies of this sort need to be tackled in counsellor training programmes and confusions related to such issues need to be clarified in counselling supervision.

10.5.2. implication for the role of counsellors as information-giver

Significantly more students than experienced counsellors thought that the funding agency would perceive the counsellor's role as "information-giver". This raises an important challenge in supervision when the role of HIV counsellor is under discussion. It was apparent that students were more likely than experienced counsellors to think that the funding agency would place emphasis on the role of HIV counsellors as providing information instead of psychological and emotional support. This suggests that supervisors will need to focus on the clarification of possible role confusions, and on how to satisfy the demands of the funding agency.

10.5.3. implication for HIV/AIDS clients' problems that might benefit more from cognitive behavioural interventions

As discussed earlier, respondents agreed that HIV counselling had aims which might be more consistent with a cognitive behavioural approach than with a humanistic model. For instance, they agreed that counsellors should aim at "helping clients to adopt safer sex practice" and "helping clients to reduce other risk factors" which were more consistent with a cognitive behavioural approach. However, they also perceived that counselling was useful in dealing with clients' problems associated with "eating disorders", "sleep disorders", and "coping with physical pains". These may be more likely to benefit more from cognitive behavioural interventions (Sikkema & Bissett, 1997) instead of a client-centred/humanistic approach. The evidence suggests that respondents may have had rather limited knowledge and awareness about these issues or they may not have thought rigorously about the relevance of their training and of their preferred orientation for working with clients with HIV/AIDS. It seems important to ensure that counsellor training programmes tackle and challenge these issues.

10.5.4. implication for counselling for suicide and bereavement of clients with HIV/AIDS

Evidence suggests that respondents perceived that counselling for people with HIV/AIDS did not require different skills and training to counselling other groups of clients, with respect to suicide, stress, depression, and bereavement. These issues were described in the literature review as difficult and problematic and counsellors were advised to receive specialised training in order to

meet their clients' demands (see sections 1.2.2d and 3.5.2c). Thus, it is possible that respondents might simply not have thought rigorously about the relevance of their training and of their preferred orientation for working with clients with HIV/AIDS. Hence, it seems desirable to ensure that counsellor training programmes tackle such issues and supervisors are aware of the possibility that counsellors might be overwhelmed by these issues faced by clients with HIV/AIDS.

Conclusions

The present investigation adds to the developmental HIV/AIDS counselling literature by being the first study to focus on the self-perceptions of experienced and student counsellors related to the role of counselling in working with clients with HIV/AIDS.

Explanations for the rationale for this research were provided and relevant literature was reviewed within the larger contexts of the theory and practice of counselling and HIV/AIDS counselling. However, little evidence has demonstrated the benefit of counselling for people infected with the virus and rigorous follow-up studies are generally lacking. A critical review of the literature draws attention to a number of authors urging the need for counselling training for helping professionals responsible for providing counselling to people with HIV/AIDS. Three issues were derived from the literature review which emphasise the significance of counselling training as preparation for working with people with HIV/AIDS.

1. It has been advised that individuals will require a considerable amount of training and/or experience in a broad range of areas if they are to feel comfortable in fulfilling the role of HIV counsellor and working within the WHO's definition (Miller & Bor, 1988; Green & McCreaner, 1989).
2. It has been recommended that those who are accorded responsibility for HIV counselling should have adequate training and/or experience in general counselling (Peckham & Newell, 1990; Coyle & Soodin, 1992).
3. Hunt (1996) argues that counsellors have an ethical obligation to be trained to adequately provide the necessary service to people who are affected with HIV/AIDS, and those who set up training programmes have an ethical obligation to provide this training.

However, whether counselling training is a necessity in the context of HIV/AIDS is not so clear cut. No evidence suggests that trained counsellors are more effective than untrained ones in providing HIV/AIDS counselling as no study has compared the outcomes of counselling of these two groups of counsellors. Moreover, whether counselling for people with HIV/AIDS requires different skills and training to counselling other groups of clients is debatable.

This thesis was accomplished by two separate studies, namely the preliminary study and the main study. When researching the potential and actual role of counselling for women with HIV/AIDS, a key question was formulated: "is counselling a central response to women with HIV/AIDS?" The results of the preliminary study suggest that counselling intervention was perceived to be of particular importance for women with HIV/AIDS as their concerns were centred more on personal needs and less on medical and practical needs. However, the results provided evidence that most counselling provided by this sample of counsellors for women with HIV/AIDS was not carried out by trained counsellors. It was concluded that counselling was not a central response to this group of clients, as workers spent more time on information and advice giving than on counselling.

The conduct of the preliminary study proved a challenge given the sensitive nature of the material it needed to access. Two major problems were identified in the preliminary study: a) many of the chosen sample were not willing to participate in the research and b) the design of the questionnaire was problematic and open to criticism. Learning from the problems encountered in the research design for the preliminary study, the questionnaire designed for the main study was undoubtedly more extensive in scope even though it is still open to scrutiny and requires future improvement.

The main study concentrated on investigating the perceptions of experienced counsellors and students selected from a counselling training centre of their role in working with people with HIV/AIDS. The main findings for the present study were a number of significant differences between the perceptions of experienced and student counsellors. However, it was disappointing to find that experienced counsellors did not appear to feel better prepared than students in working with people with HIV/AIDS.

It was anticipated that respondents selected from a humanistic counselling training centre would agree with the majority of the humanistic counsellors reviewed in the literature on the notion that HIV/AIDS counselling was not a different kind of counselling. However, inconsistent results

were found which suggest no agreement about whether counselling for people with HIV/AIDS was different from counselling other groups of clients. These results suggest that respondents might:

a) have somewhat limited knowledge and awareness about issues related to people with HIV/AIDS,
b) have not thought rigorously about the relevance of their training and of their preferred orientation for working with this group of clients, and
c) find it difficult to cope with tension between their personal beliefs/values and their preferred approach to counselling.

Therefore, in conclusion, more than half of the workers for women with HIV/AIDS, and the majority of experienced and student counsellors did not appear to feel ill-prepared and ill-equipped for their task of counselling people with HIV/AIDS. They appeared to feel that their training was adequate in preparation for working with such clients, and this was in contradiction to the literature review. The implications for the actual performance of counsellors or the quality of counselling they provide is still unknown. No published research has focused attention on the relationship between counsellors' perceptions and their performance in counselling. Thus, whether counsellors who feel well prepared and equipped will produce better counselling outcomes is extremely doubtful.

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Appendices

Appendix 5.1: Questionnaire (first study)

Confidential

COUNSELLING WOMEN WITH HIV /AIDS

I request your assistance in this research and I would be grateful if you would complete this questionnaire. Through this questionnaire I am hoping to gain insights from your first-hand experiences with your clients in order to answer the question "is counselling a central response to women with HIV/AIDS--rhetorical, potential, and actual responses?" in terms of vertical transmission of HIV. Secondly, I hope to be able to provide a contribution through this research to my own country Taiwan, in which counsellors and health professionals are uncertain and unprepared to respond to the needs and concerns of women with HIV. Their need is urgent.

The information which you give will be treated confidentially and no individual will be identifiable from any subsequent use of the form unless consent has been requested and freely given.

Please complete all the questions that apply to you. Delete any questions or sections that do not apply to you. It will take approximately 20-30 minutes to complete. A brief feedback of results will be sent to you in Spring 1996.

Catherine Hui-Wen Lin MA(ed.) in Guidance and Counselling
School of Education
University of Durham

A. Personal details

1. Please tick your Profession as a:
Doctor ☐ (1) Nurse ☐ (2) Social worker ☐ (3) Secular Counsellor ☐ (4)
Voluntary Counsellor ☐ (5) Others (please specify) ☐ (6):

_____

2. Please tick the main organisation in which you offer services to women with HIV/AIDS:
Hospital ☐ (1) Counselling centre ☐ (2) Drug advisory service ☐ (3)
Hospice ☐ (4) Social service department ☐ (5)
Others (please specify) ☐ (6) :

_____

3 Please tick any other organisations in which you offer services to women with HIV/AIDS:
Hospital ☐ (1) Counselling centre ☐ (2) Drug advisory service ☐ (3)
Hospice ☐ (4) Social service department ☐ (5)
Others (please specify) ☐ (6):

_____

B. Experience of working with women with HIV/AIDS

1. Please indicate the length of your experience working with HIV/AIDS clients (add up the length of time since you saw your first HIV client, or someone who probably had HIV if your experience predates testing). Please tick the appropriate box.
under 3 months ☐ (1) 3-6 months ☐ (2) 6-12 months ☐ (3) 1 year ☐ (4)
1-5 years ☐ (5) 5-10 years ☐ (6) over 10 years ☐ (7)

2. Please tick the approximate number of HIV positive clients seen.
1 ☐ (1) 2-5 ☐ (2) 6-10 ☐ (3) 11-15 ☐ (4) 16-20 ☐ (5) over 20 ☐ (6)

C. HIV Positive Client's Concerns

1. Please list in order of importance from one to five (1=most important, 5=least important) of the issues most frequently raised by women with concerns arising from their own HIV positive antibody status.

1	
2	
3	
4	
5	

2. Please list up to five issues to which you have found difficulty in responding to your HIV positive clients. Please place them in order of difficulty (1=most difficult, 5=least difficult).

1	
2	
3	
4	
5	

D. Interventions

1. In a normal working week, how many hours do you spend in face to face sessions (group or individual) with your HIV positive clients.

hours

2. Using the following three categories, please indicate in the table below the percentage of the total time you spend with your HIV positive clients.

(1) Information-giving: Data on key/relevant issues for the client, either reported or deemed important by the helper.
(2) Advice-giving: Helper initiated suggestion for action on medical, practical, or personal matters, a help response to request for advice.
(3) Client-centred counselling: A client-centred exploration of challenge of HIV/AIDS, in which the counsellor communicates the core conditions for effective counselling.

Categories	(1) Information-giving (%)	(2) Advice-giving (%)	(3) Client-centred counselling (%)
Time spent			

3. Please indicate for each of the three categories, how you divide your time between practical, medical and personal needs of your HIV positive clients.

(1) Information-giving	Practical needs (%)	Medical needs (%)	Personal needs (%)	Total (%)
Time spent				100%

(2) Advice-giving	Practical needs (%)	Medical needs (%)	Personal needs (%)	Total (%)
Time spent				100%

(3) Client-centred counselling	Practical needs (%)	Medical needs (%)	Personal needs (%)	Total (%)
Time spent				100%

4. Please indicate in the three tables below your time spent responding to the range of problems listed using 0 to 2 (0=none, 1= little time, 2=a lot of time). Please specify any other significant issues which are not included here.

(a) Practical issues:

Practical needs	Time spent		
	Information giving	Advice giving	Client-centred counselling
(1) Employment advice			
(2) Furniture/household appliances			
(3) Housing			
(4) Immigration/visas			
(5) Income support			
(6) Legal problems			
(7) Mobility allowance			
(8) Other financial benefits			
(9) Payment of bills			
(10) Others:			

(b) Medical issues:

Medical issues	Time spent		
	Information giving	Advice giving	Client-centred counselling
(1) Vertical transmission from mothers to babies			
(2) HIV antibody testing (post-test, positive results)			
(3) Sterile needles, syringes, water			
(4) Detoxification prescriptions			
(5) Treatment			
(6) Preventing transmission of HIV			
(7) Avoiding pregnancy			
(8) Others:			

(c) Personal issues:

Personal issues	Time spent		
	Information giving	Advice giving	Client-centred counselling
(1) Anxiety			
(2) Being expelled from home			
(3) Caring for infants with HIV/AIDS			
(4) Coming off drugs			
(5) Coping with HIV			
(6) Depression			
(7) Family problems			
(8) Feeling of guilt			
(9) Impact of child birth			
(10) Informing family of HIV status			
(11) Informing sexual partner of HIV status			
(12) Loss of health			
(13) Loss of self-esteem			
(14) Physical assault/abuse			
(15) Preparation for death of the child			
(16) Preparation for death of a partner			
(17) Preparation for death of self			
(18) Relationship problems			
(19) Relaxation training			
(20) Sexual problems			
(21) Sleeping problems			
(22) Stress			
(23) Suicidal ideations/attempts			
(24) Support in crises			
(25) Uncertainty about the baby's HIV status			
(26) Others:			

E. Methods of seeing clients

1. Please tick the appropriate box to indicate the most usual method by which you see HIV positive clients.

(1) By appointment only	
(2) Mostly by appointment	
(3) Mostly without appointment	
(4) Without appointment only	

2. Please tick the appropriate box to indicate the most usual place where you see HIV positive clients.

(1) Client comes to my centre/office	
(2) Client comes to my home	
(3) I go to see clients in their homes	
(4) I go to see clients in hospital	
(5) other - please specify	

F. Training for counselling

1. Please summarise the training you have received for all kinds of counselling.

Course title	Organisation providing the course	Year (s)	Length of training in hours	Tick if counselling formally assessed	Tick if training about HIV counselling

2. If you are an accredited counsellor, please give details.

Date accredited	Accrediting organisation

3. How adequately do you feel your training prepared you for your HIV/AIDS counselling? Please tick your response.

Very adequately ☐ (1) Adequately ☐ (2) Not sure ☐ (3)
Inadequately ☐ (4) Very inadequately ☐ (5)

4. Please indicate in which aspects of counselling you would like to receive further training.

G. What do you consider to be most important in establishing a new service to assist women with HIV/AIDS? List up to 5 indicating order of importance (1=most important, 5=least important).

1	
2	
3	
4	
5	

Thank you for your cooperation and help.

Appendix 5.2: A Letter to Workers in This Field

To:

date

Dear---

I am currently completing a PhD at Durham University in the field of "Women and the Vertical Transmission of HIV/AIDS". Initially my review of the literature led me to the belief that, given the incurable nature of the disease, the only response was prophylaxis and, if preventative measures failed, socio-emotional support for the patient. As a result, I saw counselling as a key response for those professionals working to help patients who were HIV positive or who had AIDS.

I am now conducting a questionnaire survey to differentiate three 'helping activities' in order to identify the extent to which *person-centred counselling* is available to the patients.

I would be most grateful if you would complete the enclosed questionnaire, and if possible also ask relevant colleagues to complete one too. I am aware that workers in this area are very busy and have tried to reduce the time needed to complete the questionnaire to a minimum. If it is more convenient for you, it would be possible to arrange a telephone interview. If you or a colleague are willing to participate in this additional way please complete the following contact sheet. All information received will be treated in the strictest confidence so that no individual or organisation can be identified.

Thank you in anticipation of your cooperation.

Yours sincerely,

Catherine Hui-Wen Lin

Appendix 5.3: A Reply Letter

To: Catherine Hui-Wen Lin
School of Education
University of Durham
Leazes Road
Durham DH1 1TA

Name:

Address:

(1) I am willing to be interviewed by phone on _____1995 (date), at _____(time). Tel:_____

(2) I am able to distribute_____ more copies of questionnaire.

Thank you very much for your help.

Appendix 5.4: A Reminder Letter to Workers

Address:

Dear--- Date

I asked for your help in collecting data for my research into "Counselling women with HIV/AIDS" before Christmas. I hope this letter will not seem much inappropriate or rude but I would be most grateful if it is at all possible that you could spare some time and complete the questionnaire, and return it to me by the end of February.

Also, please let me know by the same date if you or your colleagues are willing to be interviewed at the place which is convenient for you so that we can arrange a time to meet that suits your diary.

Whether or not you are able to complete the questionnaire of offer an interview, I would be also grateful if you would let me know by the end of February.

If you asked a colleague(s) to complete a questionnaire, I would be very grateful if you could also return their forms by the same date.

Your response and help will be of great value and is much appreciated. As I indicated in my earlier letter, all information received will be treated in the strictest confidence so that no individual or organisation can be identified.

Thank you in anticipation for any help you can give me. I enclosed a S.A.E. to facilitate your reply.

Yours Sincerely,

Catherine Hui-Wen Lin
(Ph.D. Student)

Appendix 5.5: A Letter from Supervisors

1st February, 1996.

Dear Colleague,

As her supervisors, we would like to add our support to the attached request from Catherine Lin for help in the collection of data for her research.

Her topic and the request, we know, make extra demands on all those who work in the field - both in terms of your work loads and the need to protect clients or patients. We are convinced, nevertheless, that Catherine's work will have positive yields for practitioners in this field, particularly in her home country of Taiwan.

Yours sincerely,

John McGuiness, Senior Lecturer in Education

Jack Gilliland, Lecturer in Education.

Appendix 5.6: A Letter to the Interviewees

Address:

Dear---

Date

Please find enclosed a copy of interview transcript. Please check the accuracy and return to me as soon as possible. Thank you very much for your time and your generous help.

Catherine Hui-Wen LIN

Appendix 5.7: A list of questions for interviews

Personal details

What is your job in this place?

What are you involving with in your work?

How do you reach out to your clients?

Counselling practice

How do you counsel clients if they need counselling?

How do you encourage your clients?

How do you empower clients?

How do you tackle the issue of helping clients to prepare for death?

Do you think your profession make people feel at ease to approach you for counselling?

Counselling training

What do you think about the value of counselling training?

Do you think having counselling training will help you in your work?

What do you think the ideal counselling setting should be?

Appendix 8.1: Questionnaire for the main study

All the instructions in this questionnaire have been written in italics to help you distinguish them from the questions.

When going through the questionnaire, please put a tick in the box corresponding to your answer, like this *Yes* ☐ *No* ☐

Sometimes you are asked to write the answer in the space provided.

A. Personal details, qualifications and trainings

1. Please tick your Profession as a: (1) Counsellor ☐ (2) Trainee counsellor ☐
   (3) Trainee counsellor undertaking placement ☐
   (4) Other, ☐ please specify:

   _____

2. Please tick whether you are: (1) Female ☐ (2) Male ☐

3. Please tick your age: (1) 21-25 ☐ (2) 26-30 ☐ (3) 31-35 ☐
   (4) 36-40 ☐ (5) over 40 ☐

4. Please tick the appropriate box to indicate the total length of your experience in some form of counselling (excluding any placement while training).
   (1) none ☐ (2) under 3 months ☐ (3) 3-6 months ☐ (4) 7-12 months ☐ (5) over 1 year ☐ (6) 2-5 years ☐
   (7) 6-10 years ☐ (8) 11-15 years ☐ (9) 16-20 years ☐
   (10) over 20 years ☐

5. Please tick your academic and professional qualifications (please tick all relevant boxes):
   (1) BA/BSc ☐ (2) Certificate in Counselling Skills ☐
   (3) Postgraduate Certificate ☐ (4) Postgraduate Diploma ☐
   (5) MA ☐ (6) MPhil ☐ (7) PhD ☐
   (8) Other, ☐ please specify:

   _____

6. Please tick whether you are an accredited counsellor: (1) Yes ☐ (2) No ☐
   If yes, please give the name of the accrediting organisation:

   _____

7. Please indicate the level of adequacy with which you feel your training has prepared you for counselling people with HIV/AIDS. Please answer question (a) by ticking 'Yes' or 'No'. If your answer to (a) is 'Yes', please tick your answer in (b).

Counselling training model(s)	(a) Have you received training in this model?	(b) Please tick the level of adequacy for your professional counselling of clients with HIV/AIDS			
		(1) very adequate	(2) adequate	(3) inadequate	(4) very inadequate
Bereavement	Yes/No	☐	☐	☐	☐
Cognitive Behavioural	Yes/No	☐	☐	☐	☐
Gestalt	Yes/No	☐	☐	☐	☐
Person-Centred/Humanistic	Yes/No	☐	☐	☐	☐
Psychodynamic	Yes/No	☐	☐	☐	☐
Rational Emotive	Yes/No	☐	☐	☐	☐
Systemic	Yes/No	☐	☐	☐	☐
Others, please specify:					
_____		☐	☐	☐	☐
_____		☐	☐	☐	☐

8. Please indicate your preferred model for counselling people with HIV/AIDS and explain the reasons for this preference.

a. Your preferred model (please tick one box only):

(1) Cognitive Behavioural ☐ (2) Gestalt ☐
(3) Person-Centred/Humanistic ☐ (4) Psychodynamic ☐
(5) Rational Emotive ☐ (6) Systemic ☐
(7) Others, ☐ please specify:

_____

b. Reasons for this preference (please tick all relevant boxes):

(1) the model fits my personality and/or values ☐
(2) the model has good research support ☐
(3) the model is logical ☐
(4) the choice of this model is based on the orientation of my supervisor ☐
(5) the choice of this model is based on my clinical experience ☐
(6) the choice of this model is based on the counselling training I have received ☐
(7) Others, ☐ please specify:

_____

9. In your view, which of the models is the best model for working with people with HIV/AIDS?

a. The best model (please tick one box only):

(1) Cognitive Behavioural ☐
(2) Gestalt ☐
(3) Person-Centred/Humanistic ☐
(4) Psychodynamic ☐
(5) Rational Emotive ☐
(6) Systemic ☐
(7) Others, ☐ please specify:

_____

b. Reasons for this:

(1)_____

(2)_____

(3)_____

10. Please summarise your initial professional qualifications as a counsellor.

(1) Organisation providing the counselling training	(2) Length of training	(3) full-time or part-time	(4) Main theoretical model(s) of the training	(5) Supervision received in hours

11. Please summarise the post-qualification courses in counselling you have taken.

(1) Organisation providing the counselling training	(2) Length of training	(3) full-time or part-time	(4) Main theoretical model(s) of the training	(5) Supervision received in hours

B. Perceptions on the role of counsellor in working with people with HIV/AIDS

1. Some frequent problems associated with HIV/AIDS are listed below. Please indicate how effective you think counselling could be in helping clients to cope with them.

Frequent problems associated with HIV/AIDS:	(1) very useful	(2) useful	(3) not very useful	(4) of very limited use
(1) Anxiety about death	☐	☐	☐	☐
(2) Anxiety in general	☐	☐	☐	☐
(3) Caring for children with or without HIV/AIDS	☐	☐	☐	☐
(4) Coming off drugs	☐	☐	☐	☐
(5) Coping with bereavement(s)	☐	☐	☐	☐
(6) Coping with physical pains	☐	☐	☐	☐
(7) Depression	☐	☐	☐	☐
(8) Difficulty in social relationships	☐	☐	☐	☐
(9) Disease progression and loss of control	☐	☐	☐	☐
(10) Eating disorders	☐	☐	☐	☐
(11) Family problems	☐	☐	☐	☐
(12) Feeling of guilt	☐	☐	☐	☐
(13) Furniture/household appliances	☐	☐	☐	☐
(14) Having a normal life	☐	☐	☐	☐
(15) HIV antibody testing (positive results)	☐	☐	☐	☐
(16) Housing	☐	☐	☐	☐
(17) Immigration/visas	☐	☐	☐	☐
(18) Informing family or sexual partner of HIV status	☐	☐	☐	☐
(19) Immediate health needs	☐	☐	☐	☐
(20) Income support and other financial benefits	☐	☐	☐	☐
(21) Legal problems	☐	☐	☐	☐
(22) Loss of health	☐	☐	☐	☐
(23) Loss of self-esteem and self-imagine	☐	☐	☐	☐
(24) Night sitting when ill	☐	☐	☐	☐
(25) Payment of bills	☐	☐	☐	☐
(26) Preparation for death of self (partner or child)	☐	☐	☐	☐
(27) Relationship problems	☐	☐	☐	☐
(28) Reproduction decision	☐	☐	☐	☐
(29) Sexual problems	☐	☐	☐	☐
(30) Sleep disorders	☐	☐	☐	☐
(31) Stress	☐	☐	☐	☐
(32) Suicidal ideations/attempts	☐	☐	☐	☐
(33) Support in crises	☐	☐	☐	☐
(34) Transport arrangements	☐	☐	☐	☐
(35) 24 hour-7 day a week home care	☐	☐	☐	☐
(36) Uncertainty about others' reactions	☐	☐	☐	☐
(37) Uncertainty about the baby's HIV status	☐	☐	☐	☐
(38) Uncertainty about the future	☐	☐	☐	☐
(39) Uncertainty about treatments	☐	☐	☐	☐
(40) Welfare of children and family	☐	☐	☐	☐
(41) Others, please specify:	☐	☐	☐	☐

2. In your view, when working with people with HIV/AIDS it is likely that: (please tick all relevant boxes)

	(1) advisor	(2) educator	(3) facilitator	(4) information - giver	(5) objective observer	(6) others, please specify: _____
(1) counsellors would perceive their own role as:	☐	☐	☐	☐	☐	☐
(2) the funding agency would perceive the counsellors' role as:	☐	☐	☐	☐	☐	☐
(3) clients would perceive the counsellors' role as:	☐	☐	☐	☐	☐	☐

3. Please indicate your level of agreement about the responses of counsellors according to the three statements below.

3(a) If the counsellor knows that an antibody positive person continues unprotected sexual activity with an unsuspecting partner.

Counsellors' responses:	(1) Strongly agree	(2) Agree	(3) Disagree	(4) Strongly disagree
Counsellors would accept the client's right to do so.	☐	☐	☐	☐
Counsellors should permit the client to make choices according to the client's own values.	☐	☐	☐	☐
Counsellor should not overlook the client's responsibility in preventing further infections to others and further deaths.	☐	☐	☐	☐
Counsellor should use all possible means to persuade clients not to place other lives at risk.	☐	☐	☐	☐
Counsellor should use all possible means to protect the third party.	☐	☐	☐	☐

3(b) If the counsellor knows that an antibody positive person goes abroad to sell blood, plasma, sperm, or even organs; or sharing needles with other drug users.

Counsellors' responses:	(1) Strongly agree	(2) Agree	(3) Disagree	(4) Strongly disagree
Counsellors would accept the client's right to do so.	☐	☐	☐	☐
Counsellors should permit the client to make choices according to the client's own values.	☐	☐	☐	☐
Counsellor should not overlook the client's responsibility in preventing further infections to others and further deaths.	☐	☐	☐	☐
Counsellor should use all possible means to persuade clients not to place other lives at risk.	☐	☐	☐	☐
Counsellor should use all possible means to protect the third party.	☐	☐	☐	☐

3(c) If the counsellor knows that an antibody positive woman decides to risk the possibility of vertical transmission and decides to get pregnant - even after having delivered an infected child.

Counsellors' responses	(1) Strongly agree	(2) Agree	(3) Disagree	(4) Strongly disagree
Counsellors would accept the client's right to do so.	☐	☐	☐	☐
Counsellors should permit the client to make choices according to the client's own values.	☐	☐	☐	☐
Counsellor should not overlook the client's responsibility in preventing further infections to others and further deaths.	☐	☐	☐	☐
Counsellor should use all possible means to persuade clients not to place other lives at risk.	☐	☐	☐	☐
Counsellor should use all possible means to protect the third party.	☐	☐	☐	☐

4. In your view, when working with people with HIV/AIDS, counsellors will need to aim at (please tick your responses to indicate the degree of agreement):

	(1) strongly agree	(2) agree	(3) disagree	(4) strongly disagree
(1) making sure that clients know how to reach the counsellor in case of difficulty	☐	☐	☐	☐
(2) being approachable	☐	☐	☐	☐
(3) being caring	☐	☐	☐	☐
(4) being directive	☐	☐	☐	☐
(5) listening carefully to clients' responses and helping them to talk through what HIV/AIDS means to them	☐	☐	☐	☐
(6) being non-directive	☐	☐	☐	☐
(7) providing information about infection control issues	☐	☐	☐	☐
(8) being sensitive to client's needs	☐	☐	☐	☐
(9) being understanding	☐	☐	☐	☐
(10) encouraging clients to prepare for death	☐	☐	☐	☐
(11) encouraging clients to take positive steps to maintain and improve general health	☐	☐	☐	☐
(12) having good networks with other professionals	☐	☐	☐	☐
(13) helping clients to arrange a social support network or to make the best use of them	☐	☐	☐	☐
(14) helping clients to deal with relationship issues	☐	☐	☐	☐
(15) helping clients to decide who else they wished to tell about their HIV status	☐	☐	☐	☐
(16) helping clients to adopt safer sex practice	☐	☐	☐	☐
(17) being accepting	☐	☐	☐	☐
(18) providing facts about HIV/AIDS	☐	☐	☐	☐
(19) helping client with practical problems such as housing, welfare benefits, etc.	☐	☐	☐	☐
(20) being non-judgmental	☐	☐	☐	☐
(21) informing clients about what hospital and voluntary services are available and how to access them	☐	☐	☐	☐
(22) improving clients' self-concept and self-esteem	☐	☐	☐	☐
(23) helping clients to reduce other risk factors	☐	☐	☐	☐
(24) being supportive	☐	☐	☐	☐
(25) preventing the spread of HIV infection and AIDS	☐	☐	☐	☐
(26) being friendly	☐	☐	☐	☐
(27) promoting behaviour and attitude change	☐	☐	☐	☐
(28) making sure that clients have adequate medical support and services	☐	☐	☐	☐
(29) reducing anxiety and depression	☐	☐	☐	☐
(30) helping clients to inform sexual partners	☐	☐	☐	☐
(31) showing empathy	☐	☐	☐	☐
(32) providing facts about transmission	☐	☐	☐	☐
(33) others - please specify				
_____	☐	☐	☐	☐

5. Do you agree that in order to be honest, in counselling settings, counsellors should be willing to disclose their own values. (1) Yes ☐ (2) No ☐

6. In your view, are counsellors able to be value-neutral or value-free in the context of HIV/AIDS?
(1) Yes ☐ (2) No ☐

7. Have you had any experience counselling people without HIV/AIDS who nevertheless had concerns about HIV/AIDS?
(1) Yes, ☐ please specify the concerns: (2) No ☐

_____

_____

_____

8. Is there anything else you would like to say about the role of counsellors in working with people with HIV/AIDS?

(1)_____

_____

_____

(2)_____

_____

_____

C. This section is for people who have had experience in working with people with HIV/AIDS

1. Please tick the appropriate box to indicate the length of your experience working with HIV/AIDS clients (the length of time since you saw your first HIV client, or someone who probably had HIV if the start of counselling predated testing).

(1) under 3 months ☐ (2) 3-6 months ☐ (3) 7-12 months ☐
(4) over 1 year ☐ (5) 2-5 years ☐ (6) 6-10 years ☐
(7) 11-15 years ☐ (8) over 15 years ☐

2. As a counsellor, have you accepted referrals of clients with HIV/AIDS from other agencies?

(1) Yes ☐ (2) No ☐

3. Have you had experience counselling people with HIV/AIDS in which the clients were not initially aware of their HIV status? (1) Yes ☐ (2) No ☐

4. Have you had experience counselling people with HIV/AIDS without yourself initially being aware of their HIV status? (1) Yes ☐ (2) No ☐

5. As a counsellor, have you accepted referrals of clients with HIV/AIDS for reasons other than HIV/AIDS?

(1) Yes, ☐ please specify the reasons: (2) No ☐

_____

_____

_____

6. Please tick the approximate number of HIV/AIDS clients seen.

(1) under 6 ☐ (2) 6-10 ☐ (3) 11-15 ☐ (4) 16-20 ☐
(5) 21-25 ☐ (6) 26-30 ☐ (7) 26-30 ☐ (8) 31-35 ☐ (9) over 35 ☐

7. Please write down the appropriate number of clients to indicate the groups of your HIV/AIDS clients seen.

Client groups	number of clients
Female	
Male	
Ethnic origin:	
African/African-Caribbean	
Asian	
White	
Others, please specify:	

D. Optional section

1. If you have had working experience with people with HIV/AIDS, and would be willing to be interviewed at a later stage, please leave your name and address:

_____

_____

_____

2. If you would like to receive a brief report of my research, please leave your name and address:

_____

_____

_____

Thank you very much for your help. Please return this questionnaire by 3 December 1998.

Appendix 8.2: Pilot study - Questionnaire

All the instructions in this questionnaire have been written in italics to help you distinguish them from the questions.

Please ignor the number on the right side of the page throughout this questionnaire. They are there for the purpose of data analysis only.

When going through the questionnaire, please put a tick in the box corresponding to your answer, like this *Yes* ☐ *No* ☐

Sometimes you are asked to write the answer in the space provided.

A. Personal details

1. Please tick your Profession as a: (1) Counsellor ☐ (2) Trainee counsellor ☐
(3) Other, ☐ please specify:
_____

2. Please tick whether you are: (1) Female ☐ (2) Male ☐

3. Please tick your age: (1) 21-25 ☐ (2) 26-30 ☐ (3) 31-35 ☐
(4) 36-40 ☐ (5) over 40 ☐

4. Please tick the appropriate box to indicate the total length of your counselling experience (excluding your training). (1) under 3 months ☐ (2) 3-6 months ☐
(3) 7-12 months ☐ (4) over 1 year ☐ (5) 2-5 years ☐ (6) 6-10 years ☐
(7) 11-15 years ☐ (8) 16-20 years ☐ (9) over 20 years ☐

5. Please tick your academic and professional qualifications (please tick all relevant boxes):
(1) BA ☐ (2) Diploma ☐ (3) MA ☐ (4) MPhil ☐
(5) PhD ☐ (6) Other, ☐ please specify:
_____

6. Please tick whether you are an accredited counsellor: (1) Yes ☐ (2) No ☐

7. Please summarise your initial professional qualifications as a counsellor.

(1) Organisation providing the counselling training	(2) Length of training	(3) full-time or part-time	(4) Main theoretical model(s) of the training	(5) Supervision received in hours

8. Please summarise the post-qualification courses in counselling you have taken.

(1) Organisation providing the counselling training	(2) Length of training	(3) full-time or part-time	(4) Main theoretical model(s) of the training	(5) Supervision received in hours

B. Perceptions on the role of counsellor in working with people with HIV/AIDS

1. Some frequent problems associated with HIV/AIDS are listed below. Please indicate how effective you think counselling could be in helping clients to cope with them.

Frequent problems associated with HIV/AIDS:	(1) very useful	(2) useful	(3) not very useful	(4) of very limited use
(1) Anxiety about death	☐	☐	☐	☐
(2) Anxiety in general	☐	☐	☐	☐
(3) Caring for children with or without HIV/AIDS	☐	☐	☐	☐
(4) Coming off drugs	☐	☐	☐	☐
(5) Coping with bereavement(s)	☐	☐	☐	☐
(6) Coping with physical pains	☐	☐	☐	☐
(7) Depression	☐	☐	☐	☐
(8) Difficulty in social relationships	☐	☐	☐	☐
(9) Disease progression and loss of control	☐	☐	☐	☐
(10) Eating disorders	☐	☐	☐	☐
(11) Family problems	☐	☐	☐	☐
(12) Feeling of guilt	☐	☐	☐	☐
(13) Furniture/household appliances	☐	☐	☐	☐
(14) Having a normal life	☐	☐	☐	☐
(15) HIV antibody testing (positive results)	☐	☐	☐	☐
(16) Housing	☐	☐	☐	☐
(17) Immigration/visas	☐	☐	☐	☐
(18) Informing family or sexual partner of HIV status	☐	☐	☐	☐
(19) Immediate health needs	☐	☐	☐	☐

	(1) very useful	(2) useful	(3) not very useful	(4) of very limited use
(20) Income support and other financial benefits	☐	☐	☐	☐
(21) Legal problems	☐	☐	☐	☐
(22) Loss of health	☐	☐	☐	☐
(23) Loss of self-esteem and self-imagine	☐	☐	☐	☐
(24) Night sitting when ill	☐	☐	☐	☐
(25) Payment of bills	☐	☐	☐	☐
(26) Preparation for death of self (partner or child)	☐	☐	☐	☐
(27) Relationship problems	☐	☐	☐	☐
(28) Reproduction decision	☐	☐	☐	☐
(29) Sexual problems	☐	☐	☐	☐
(30) Sleep disorders	☐	☐	☐	☐
(31) Stress	☐	☐	☐	☐
(32) Suicidal ideations/attempts	☐	☐	☐	☐
(33) Support in crises	☐	☐	☐	☐
(34) Transport arrangements	☐	☐	☐	☐
(35) 24 hour-7 day a week home care	☐	☐	☐	☐
(36) Uncertainty about others' reactions	☐	☐	☐	☐
(37) Uncertainty about the baby's HIV status	☐	☐	☐	☐
(38) Uncertainty about the future	☐	☐	☐	☐
(39) Uncertainty about treatments	☐	☐	☐	☐
(40) Welfare of children and family	☐	☐	☐	☐
(41) Others, please specify:				
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐

2. In your view, when working with people with HIV/AIDS it is likely that:
(please tick all relevant boxes)

	(1) advisor	(2) educator	(3) facilitator	(4) information - giver	(5) objective observer	(6) others, please specify: _____
(1) counsellors would perceive their own role as:	☐	☐	☐	☐	☐	☐
(2) the funding agency would perceive the counsellors' role as:	☐	☐	☐	☐	☐	☐
(3) clients would perceive the counsellors' role as:	☐	☐	☐	☐	☐	☐

3. Please indicate your level of agreement about the responses of counsellors according to the three statements below.

a. If the counsellor knows that an antibody positive person continues unprotected sexual activity with an unsuspecting partner.

Counsellors' responses:	(1) Strongly agree	(2) Agree	(3) Disagree	(4) Strongly disagree
Counsellors would accept the client's right to do so.	☐	☐	☐	☐
Counsellors should permit the client to make choices according to the client's own values.	☐	☐	☐	☐
Counsellor should not overlook the client's responsibility in preventing further infections to others and further deaths.	☐	☐	☐	☐
Counsellor should use all possible means to persuade clients not to place other lives at risk.	☐	☐	☐	☐
Counsellor should use all possible means to protect the third party.	☐	☐	☐	☐

b. If the counsellor knows that an antibody positive person goes abroad to sell blood, plasma, sperm, or even organs; or sharing needles with other drug users.

Counsellors' responses:	(1) Strongly agree	(2) Agree	(3) Disagree	(4) Strongly disagree
Counsellors would accept the client's right to do so.	☐	☐	☐	☐
Counsellors should permit the client to make choices according to the client's own values.	☐	☐	☐	☐
Counsellor should not overlook the client's responsibility in preventing further infections to others and further deaths.	☐	☐	☐	☐
Counsellor should use all possible means to persuade clients not to place other lives at risk.	☐	☐	☐	☐
Counsellor should use all possible means to protect the third party.	☐	☐	☐	☐

c. If the counsellor knows that an antibody positive woman decides to risk the possibility of vertical transmission and decides to get pregnant - even after having delivered an infected child.

Counsellors' responses	(1) Strongly agree	(2) Agree	(3) Disagree	(4) Strongly disagree
Counsellors would accept the client's right to do so.	☐	☐	☐	☐
Counsellors should permit the client to make choices according to the client's own values.	☐	☐	☐	☐
Counsellor should not overlook the client's responsibility in preventing further infections to others and further deaths.	☐	☐	☐	☐
Counsellor should use all possible means to persuade clients not to place other lives at risk.	☐	☐	☐	☐
Counsellor should use all possible means to protect the third party.	☐	☐	☐	☐

4. In your view, when working with people with HIV/AIDS, counsellors will need to aim at (please tick your responses to indicate the degree of agreement):

	(1) strongly agree	(2) agree	(3) disagree	(4) strongly disagree
(1) making sure that clients know how to reach the counsellor in case of difficulty	☐	☐	☐	☐
(2) being approachable	☐	☐	☐	☐
(3) being caring	☐	☐	☐	☐
(4) being directive	☐	☐	☐	☐
(5) listening carefully to clients' responses and helping them to talk through what HIV/AIDS means to them	☐	☐	☐	☐
(6) being non-directive	☐	☐	☐	☐
(7) providing information about infection control issues	☐	☐	☐	☐
(8) being sensitive to client's needs	☐	☐	☐	☐
(9) being understanding	☐	☐	☐	☐
(10) encouraging clients to prepare for death	☐	☐	☐	☐
(11) encouraging clients to take positive steps to maintain and improve general health	☐	☐	☐	☐
(12) having good networks with other professionals	☐	☐	☐	☐
(13) helping clients to arrange a social support network or to make the best use of them	☐	☐	☐	☐
(14) helping clients to deal with relationship issues	☐	☐	☐	☐
(15) helping clients to decide who else they wished to tell about their HIV status	☐	☐	☐	☐
(16) helping clients to adopt safer sex practice	☐	☐	☐	☐
(17) being accepting	☐	☐	☐	☐
(18) providing facts about HIV/AIDS	☐	☐	☐	☐

	(1) strongly agree	(2) agree	(3) disagree	(4) strongly disagree
(19) helping client with practical problems such as housing, welfare benefits, etc..	☐	☐	☐	☐
(20) being non-judgmental	☐	☐	☐	☐
(21) informing clients about what hospital and voluntary services are available and how to access them	☐	☐	☐	☐
(22) improving clients' self-concept and self-esteem	☐	☐	☐	☐
(23) helping clients to reduce other risk factors	☐	☐	☐	☐
(24) being supportive	☐	☐	☐	☐
(25) preventing the spread of HIV infection and AIDS	☐	☐	☐	☐
(26) being friendly	☐	☐	☐	☐
(27) promoting behaviour and attitude change	☐	☐	☐	☐
(28) making sure that clients have adequate medical support and services	☐	☐	☐	☐
(29) reducing anxiety and depression	☐	☐	☐	☐
(30) helping clients to inform sexual partners	☐	☐	☐	☐
(31) showing empathy	☐	☐	☐	☐
(32) providing facts about transmission	☐	☐	☐	☐
(33) others - please specify				
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐

5. Do you agree that in order to be honest, in counselling settings, counsellors should be willing to disclose their own values. (1) Yes ☐ (2) No ☐

6. In your view, are counsellors able to be value-neutral or value-free in the context of HIV/AIDS?
(1) Yes ☐ (2) No ☐

7. Is there anything else you would like to say about the role of counsellors in working with people with HIV/AIDS?

(1)_____

_____

_____

(2)_____

_____

_____

(3)_____

_____

_____

C. Experience in working with people with HIV/AIDS

1. Have you had any experience counselling people with HIV/AIDS?
(1) Yes ☐ (2) No ☐ (3) No, but considering a request ☐

2. Please tick the appropriate box to indicate the length of your experience working with HIV/AIDS clients (the length of time since you saw your first HIV client, or someone who probably had HIV if the start of counselling predated testing).

(1) under 3 months ☐ (2) 3-6 months ☐ (3) 7-12 months ☐
(4) over 1 year ☐ (5) 2-5 years ☐ (6) 6-10 years ☐
(7) 11-15 years ☐ (8) over 15 years ☐

3. As a counsellor, have you accepted referrals of clients with HIV/AIDS from other agencies?

(1) Yes ☐ (2) No ☐

4. Have you had experience counselling people with HIV/AIDS in which the clients were not initially aware of their HIV status? (1) Yes ☐ (2) No ☐

5. Have you had experience counselling people with HIV/AIDS without yourself initially being aware of their HIV status? (1) Yes ☐ (2) No ☐

6. Please indicate the level of adequacy with which you feel your training has prepared you for counselling people with HIV/AIDS. Please answer question (a) by ticking 'Yes' or 'No'. If your answer to (a) is 'Yes', please tick your answer in (b).

Counselling training model(s)	(a) Have you received training in this model?	(b) Please tick the level of adequacy for your professional counselling of clients with HIV/AIDS			
		(1) very adequate	(2) adequate	(3) inadequate	(4) very inadequate
Bereavement	Yes/No	☐	☐	☐	☐
Cognitive Behavioural	Yes/No	☐	☐	☐	☐
Gestalt	Yes/No	☐	☐	☐	☐
Person-Centred/Humanistic	Yes/No	☐	☐	☐	☐
Psychodynamic	Yes/No	☐	☐	☐	☐
Rational Emotive	Yes/No	☐	☐	☐	☐
Systemic	Yes/No	☐	☐	☐	☐
Others, please specify:					
_____		☐	☐	☐	☐
_____		☐	☐	☐	☐
_____		☐	☐	☐	☐

7. Please indicate your preferred model for counselling people with HIV/AIDS and explain the reasons for this preference.

a. Your preferred model (please tick one box only):

(1) Bereavement ☐ (2) Cognitive Behavioural ☐ (3) Gestalt ☐
(4) Person-Centred/Humanistic ☐ (5) Psychodynamic ☐
(6) Rational Emotive ☐ (7) Systemic ☐
(8) Others, ☐ please specify:

_____

b. Reasons for this preference (please tick all relevant boxes):

(1) the model fits my personality and/or values ☐
(2) the model has good research support ☐
(3) the model is logical ☐
(4) the choice of this model is based on the orientation of my supervisor ☐
(5) the choice of this model is based on my clinical experience ☐
(6) the choice of this model is based on the counselling training I have received ☐
(7) Others, ☐ please specify:

_____

8. In your view, which of the models is the best model for working with people with HIV/AIDS?

a. The best model (please tick one box only):

(1) Bereavement ☐ (2) Cognitive Behavioural ☐ (3) Gestalt ☐
(4) Person-Centred/Humanistic ☐ (5) Psychodynamic ☐
(6) Rational Emotive ☐ (7) Systemic ☐
(8) Others, ☐ please specify:

_____

b. Reasons for this:

(1)_____

(2)_____

(3)_____

(4)_____

(5)_____

9. As a counsellor, have you accepted referrals of clients with HIV/AIDS for reasons other than HIV/AIDS?

(1) Yes, ☐ please specify the reasons: (2) No ☐

_____

_____

_____

10. Have you had any experience counselling people without HIV/AIDS who nevertheless had concerns about HIV/AIDS?

(1) Yes, ☐ please specify the concerns: (2) No ☐

_____

_____

_____

11. Please tick the approximate number of HIV/AIDS clients seen.

(1) under 6 ☐ (2) 6-10 ☐ (3) 11-15 ☐ (4) 16-20 ☐

(5) 21-25 ☐ (6) 26-30 ☐ (7) 26-30 ☐ (8) 31-35 ☐ (9) over 35 ☐

12. Please write down the appropriate number of clients to indicate the groups of your HIV/AIDS clients seen.

Client groups	number of clients
Female	
Male	
Ethnic origin:	
African/African-Caribbean	
Asian	
White	
Others, please specify:	

D. Optional section

1. If you have had working experience with people with HIV/AIDS, and would be willing to be interviewed at a later stage, please leave your name and address:

_____

_____

_____

2. If you would like to receive a brief report of my research, please leave your name and address:

_____

_____

_____

3. Please tick the length of time it would take to complete the questionnaire.

(1) approx. 25 mins ☐ (2) approx. 30 mins ☐ (3) approx. 35 mins ☐
(4) approx. 40 mins ☐ (5) approx. 45 mins ☐ (6) approx. 50 mins ☐
(7) approx. 55 mins ☐ (8) approx. 1 hour ☐
(9) more than 1 hour ☐ please specify the time:

_____

Thank you very much for your help. Please return this questionnaire by ??.

Appendix 8.3: A letter to participants for the pilot study

Catherine H-W Lin
School of Education
University of Durham
Leazes Road
Durham DH1 1TA

20 Sept. 1998

Dear

Please read through the whole questionnaire and try to answer as many questions as you can. Please note down two things while you are answering the questions.

1. Please read the questions carefully and check if all questions are clear. Please feel free to write your comments next to the question or on a separate sheet.

2. Please watch the time you would spend on answering this questionnaire and indicate the time spent in D3.

Please return the questionnaire no later than

Thank you very much for your time and your generous help is most appreciated.

Catherine H-W Lin
PhD Student, School of Education
University of Durham

Appendix 8.4: A Letter to Students attending counselling courses

Catherine H-W Lin
School of Education
University of Durham
Leazes Road
Durham DH1 1TA

23 Nov 1998

Dear Colleague,

I took the MA in Guidance and Counselling at Durham University. As part of my research at Durham University, I am interested in the perceptions of experienced and trainee counsellors of their role in working with people who are HIV positive or who have AIDS. There seems to be remarkably little good quality information on this important area of work, and the aim of my doctoral research is to make some progress in filling this gap. It would be helpful if you would complete the enclosed questionnaire. The form can be filled in anonymously and no working experience with people who are HIV positive or who have AIDS is required.

However, I am also hoping to meet a small group of counsellors who have had experience of working with clients who are HIV positive, or who have AIDS. The purpose of these meetings would be to seek future information on the counsellors' experience, and on their priorities in working with their clients. If you have had such experience and would be willing to meet me for 30-50 minutes, please would you complete the optional section D1 for your name and address. If you would like to receive a brief report of my research, would you please complete the optional section D2 for your name and address. I hope my research will help me in my future work with clients who have HIV/AIDS in Taiwan. It should take approximately 35 minutes to complete the questionnaire. Your reply will be treated in strict confidence. A stamped addressed envelope is enclosed for your reply. Please return this questionnaire by 3 December 1998.

Thank you very much for your help.

Yours Faithfully,

Catherine H-W Lin
PhD Student, School of Education

Appendix 8.5: A letter to supervisors

Catherine H-W Lin
School of Education
University of Durham
Leazes Road
Durham DH1 1TA

19 Nov 1998

I am carrying out research on the subject of counselling clients who are HIV positive or who have AIDS, and I have discussed my work with Peter Cook, Director of the Centre for Studies in Counselling (CESCO). I do hope you won't mind me writing to you at his suggestion.

I took the MA(ed) in Guidance and Counselling at Durham University. As part of my current doctoral research, I am interested in the perceptions of experienced and trainee counsellors of their role in working with people who are HIV positive or who have AIDS. There seems to be remarkably little good quality information on this important area of work, and the aim of my doctoral research is to make some progress in filling this gap. It would be helpful if you would complete the enclosed questionnaire. The form can be filled in anonymously and no working experience with people who are HIV positive or who have AIDS is required.

However, I am also hoping to meet a small group of counsellors who have had experience of working with clients who are HIV positive, or who have AIDS. The purpose of these meetings would be to seek future information on the counsellors' experience, and on their priorities in working with their clients. If you have had such experience and would be willing to meet me for 30-50 minutes, please would you complete the optional section D1 with your name and address. If you would like to receive a brief report of my research, would you please complete the optional section D2. I hope my research will help me in my future work with clients who have HIV/AIDS in Taiwan. It should take approximately 35 minutes to complete the questionnaire. Your reply will be treated in strict confidence. A stamped addressed envelope is enclosed for your reply. Please return this questionnaire by 3 December 1998.

Thank you very much for your help.
Yours sincerely,

Catherine H-W Lin (PhD Student, School of Education)

Appendix 8.6: A letter to Tutors

Catherine Lin
School of Education
University of Durham

17 November 1998

To: Tutors in CESCO
School of Education
University of Durham

Dear

Referring to the letter addressed to you by Peter Cook last week, I am writing to ask for your permission to give my questionnaire to your students. It would be very helpful if you could allow me five minutes at the beginning or end of a session, or before a break, to tell students about my research and ask for their help.

Can I come to your class(es) on

_____

_____

Please let me know if the above date(s) is convenient for you. If not, please let me know your alternative date.

Please drop me a note through internal mail, or e-mail (c.h.lin@durham.ac.uk), or leave a message on the answering machine at home (0191-386 1559).

Thank you very much for your generous help.

Catherine H-W Lin
(PhD student)

Appendix 8.7: A short introduction of the research

I would like to tell you briefly about my research and ask for your help.

1. I have carried out a first study on the issues involved in counselling women who were HIV positive or who had AIDS. The study was carried out among a small group of people in 1996.
2. The results were interesting but demonstrated that most counselling for women who were HIV positive or who had AIDS were not carried out by trained counsellors in those organisations I contacted for the study.
3. The results of the first study and the review of the literature convinced me of a need to seek further information about the perceptions of trainee counsellors and trained or experienced counsellors on the issues involved in counselling people with HIV or AIDS.
4. There are two major issues in this main study I am doing now. The first one is the issue of different definitions of counselling adopted by the British Association for Counselling and the World Health Organisation. The second one is whether counselling people who are HIV positive or who have AIDS requires different skills and training to other groups of clients.
5. With the approval of the Director and the consent of tutors, I am now asking current students for help in the completion of the questionnaire.
6. A summary of my findings will be sent to everybody who requests it and I would like to invited everybody who is interested in this subject to attend an evening seminar at which I will present the results for discussion.
7. The purpose of my visit today is to give everybody a questionnaire and ask for your help in completing it. I have enclosed a stamped addressed envelop for your reply. Thank you very much.

Appendix 8.8: A letter from the course director to students and supervisors

Catherine Lin has sought permission to approach student counsellors and experienced counsellors through Centre for Studies in Counselling as part of her research. I hope you will be able to assist her in her studies.

Yours sincerely,

Course Director

Appendix 8.9: Reminder

Catherine H-W Lin
School of Education
University of Durham
Leazes Road
Durham DH1 1TA

25 January 1999

Dear Colleague,

Re: Working with People with HIV/AIDS: The Perceptions of Trainee and Experienced Counsellors

You will remember that I asked for your help before Christmas in completing this questionnaire. I have now received 31% questionnaires back, and I would like to thank everyone who has returned them. The results are proving extremely interesting and helpful, and I will send a summary to colleages who asked for one.

However, quite a number of people have not returned the questionnaire. Christmas and New Year are busy times. I hope you won't mind me including a second copy in case you have mislaid your original one over the holiday period. In order to reflect the views of counsellors and trainees accurately, we obviously need a good response, so if you have not already done so, I would be very grateful if you could return the completed questionnaire by 5th February 1999 in the enclosed stamped addressed envelope.

Of course, if you were one of the people who did return the questionnaire, may I thank you again and please accept my apologies for troubling you. As before, all response will be treated in the strictest confidence.

With best wishes for 1999.

Catherine H-W Lin
PhD student

PS: Please would you return the questionnaire even if you have not had any experience in working with clients with HIV/AIDS. Your replies will still be very useful.

Appendix 8.10: A letter from my supervisor

19th January, 1999

Dear Colleague,

Could I thank all of you who returned the questionnaire which Catherine Lin, one of our PhD students form Taiwan, gave you before Christmas on the Perceptions of Trainee and Experienced counsellors of their Role in Working with People with HIV/AIDS. The responses which have already arrived are proving very interesting and should make a useful contribution to the literature on this important subject.

You are all busy people, and it is inevitable that some of you have not yet returned the questionnaire. If you have returned it, please accept our thanks and ignore this letter and the attachments. For the rest of you, another letter from Catherine is enclosed, with a second copy of the questionnaire. If you could find time to complete it and return it to her by 10th February, both she and I would be very grateful indeed. We will, of course, send a summary to everyone who would like one.

With best wishes for 1999.

Yours sincerely,

David Galloway
Head of School of Education

Appendix 9.1: Coding of responses to questionnaire

Question	Variable	Coding
A1 Profession	Pro	1 = Counsellor 2 = Trainee counsellor 3 = Trainee counsellor undertaking placement 4 = Other
A2 Sex	Sex	1 = Female 2 = Male
A3 Age	Age	1 = 21-25 2 = 26-30 3 = 31-35 4 = 36-40 5 = over 40
A4 Length of counselling	Year	1= none 2 = under 3 months 3 = 3-6 months 4 = 7-12 months 5 = over 1 year 6 = 2-5 years 7 = 6-10 years 8 = 11-15 years 9 = 16-20 years 10 = over 20 years
A5 Qualification	A5	1 = BA/BSc 2 = Certificate in Counselling Skills 3 = Postgraduate Certificate 4 = Postgraduate Diploma 5 = MA 6 = MPhil 7 = PhD 8 = Other
A6 Accreditation	A6	1 = Yes 2 = No
A7 Level of adequacy	A7a A7b	1 = Yes 2 = No 4 = very adequate 3 = adequate 2 = inadequate 1= very inadequate
A8a Preferred model A9 Best model	A8 & A9	1 = Cognitive Behavioural 2 = Gestalt 3 = Person-centred/Humanistic 4 = Psychodynamic 5 = Rational Emotive 6 = Systemic 7 = others
A8b Reasons	A8b	1 = the model fits my personality and/or values 2 = the model has good research support 3 = the model is logical 4 = the choice of this model is based on the orientation of my supervisor 5 = the choice of this model is based on my clinical experience 6 = the choice of this model is based on the counselling training I have received 7 = Others
B1 Usefulness of counselling	B1.1 to B1.40	4 = very useful 3 = useful 2 = not very useful 1 = of very limited use
B2 Role of counsellor	B2.11 to B2.35	1 = advisor 2 = educator 3 = facilitator 4 = information-giver 5 = objective observer
B3 Agreements	B3.11 to B3.35	4 = Strongly agree 3 = Agree 2 = Disagree 1 = Strongly disagree
B4 Aims	B4.1 to B4.32	4 = Strongly agree 3 = Agree 2 = Disagree 1 = Strongly disagree
B5 to B7	B5 to B7	1 = Yes 2 = No
C1 Length of counselling with clients with HIV/AIDS	C1	1 = under 3 month 2 = 3-6 months 3 = 7-12 months 4 = over 1 year 5 = 2-5 years 6 = 6-10 years 7 = 11-15 years 8 = over 15 years
C2 to C5	C2 to C5	1 = Yes 2 = No
C6 Number of clients	C6	1 = under 6 2 = 6-10 3 = 11-15 4 = 16-20 5 = 21-15 6= 26-30 8 = 31-35 9 = over 35

Appendix 9.2: Open questions

Question A7: Other models of counselling training received

Other counselling training model(s) respondents have received	Number of respondents (n = 14)			
	very adequate	adequate	inadequate	very inadequate
Co-counselling	1			
Feminist	1			
Gay affirmative	1			
Hypnotherapy			1	
Inner child	1			
Motivational			2	
NLP		1	1	
Pastoral care training	1			
Problem Solving	1		1	
Sexual Abuse		1		
Solution focused	1	1	1	
Transactional analysis			1	1

Question A8: Preferred model

Others:	
Egan/Pastoral care	1
Life biography	1
Existential because actively phenomenological	1
Grovian Metaphor therapy	1
respondents did not answer this question because:	
Find it difficult to cling to one model permanently!	1
Start with what the client wants	1
It would depend on the person and the issues they were bringing	1
Reasons for this preference:	
It follows on from my health visiting approach.	1
Because of the three core conditions - ideal for restoration for those with HIV diagnosis	2
	1
I think the depth of therapeutic relationship established is fundamental important	1
It would depend on the person and the issues they were bringing	1
Non-directive - these clients are already receiving large amounts of direction from other professionals	1

QA9b. Reasons for this preference

S2 (1) As a means of exploring feelings, thoughts, where client's at.
(2) Moving on to finding ways of coping with HIV/AIDS, perhaps.

S3 (1) It respects client's Autonomy.
(2) It can help client to explore choices rather than impose them.

S4 (1) I do not suffer from HIV/AIDS, therefore the client's feelings are the only guide.
(2) It is the only model I have significant experience in.

S5 (1) This is the only training I have but I believe it to be of more value.
(2) To enable client to make sense of life and death.

S8 It's the one I use.

S10 I believe it be most suitable for people with HIV/AIDS.

S14 Because of the core condition of empathy, congruence and particularly unconditional positive regard.

S15 Help clients to deal with their inner self and to have better understanding of the others.

S18 I am trained in this approach but I think other models e.g. Cognitive Behavioural could be added to this.

S19 (1) Client is "expert" on self at a time when other experts discover and support self-actualisation.
(2) Acceptance of client's feelings .

S20 (1) Valuing and affirming the person when HIV/AIDS is often isolating.
(2) Therapeutic relationship is beneficial

S21 (1) Provides the tools for helping with problems associated with HIV/AIDS.
(2) Allows the client to make choices according to their own values.
(3) Allows counsellor to disclose own values particularly on ethical issues.

S23 (1) listening and support is helpful
(2) life biography looks at 'life chooses' that were taken.

S24 (1) respect for and gives dignity to client
(2) offers client chance to use counselling for their agenda
(3) Accepting and non-judgmental

S26 (1) This model is the only one I am familiar with.
(2) No harm can come to the client (in the relationship).
(3) Client is placed in a safe relationship.

S27 (1) Expression of deep feelings.
(2) Self acceptance, self esteem, courage to fight illness.
(3) Deep shared understanding, hope, dignity vs. fear.

S28 (1) Allows clients to explore feelings around loss, death.
(2) Allows clients to work through difficulties in relationships.
(3) Helps clients with changing circumstances.

S30 Personal experience suggests that this model works well for most problems.

S33 Crucial importance of core conditions for self-acceptance.

S34 It allows the individual to be accepted.

S37 (1) Works in the here and now but also allows exploration.
(2) Is both practical and supportive.
(3) Agenda is driven by client.

S38 (1) Work with what is given in the present moment.
(2) Core conditions are essential for supporting people living with HIV/AIDS

S39 (1) Responsive to the client's need.
(2) Allows me to draw on my training.
(3) Allows me to draw on my experience.

S40 (1) It respects the person.
(2) It respects their situation.
(3) it accept everything as the client sees, feels, and perceives.

S42 Existential: because phenomenological

S47 Very helpful and close to human beings.

S49 Grovian metaphor therapy:
(1) provides a cognitive map of psychic structures
(2) Integrates the intrapersonal with the interpersonal
(3) clients can work at the level of symbol and anonymous their experience if they wish.

S50 Humanistic/person-centred is about the relationship which will be imperative to the HIV/AIDS clients.

S51 (1) This model appears to have reasonable success.
(2) It suits my personal approach.

S52 (1) It is what I work with. (2) It is deeply respectful of clients. (3) It works.

S54 (1) Core-conditions ideal for restoration for those with HIV diagnosis.
(2) Non-directive - these clients are already receiving large amounts of direction from other professionals.

S55 (1) Client autonomy (2) Is here and now (3) Is non-invasive

S57 (1) It works with the client's feelings and awareness - a major aspect of the experience of HIV/AIDS.
(2) It emphasises acceptance, empathy and congruence - important for client to feel accepted and understood.

S61 (1) It can address the whole person and the whole context.
(2) It is respectful of actual power in balance.
(3) It encompasses insights.

S62 Isn't as much about doing as being, allows people to explore how they feel and find out what they need and what they want.

S63 Core conditions necessary - to be non-judgmental.

S64 I believe the therapy.

S65 Problem focused.

S66 (1) The client is central.
(2) The client knows what is best for him/her.
(3) The equality of the relationship.

S67 I don't think this would necessarily or always be the best model fro working with HIV/AIDS, it depends on what they are coming for but it is a good one if I am found to choose one.

S68 (1) Acceptance of individual, congruence of counsellor.
(2) Non-judgmental of individual. (3) Communicating empathy.

S69 Core conditions.

S70 Need for a supportive, human response when facing life/death situation.

S71 Gestalt therapy is based on awareness of the here and now.

S72 It offers the client a secure basis from which to work through feelings.

S74 People with HIV/AIDS are not specifically different to any others and I mainly use one approach.

S75 (1) Treat person as unique. (2) Work from their frame of reference.

S76 Possibly person-centred/humanistic might be able to support the client's emotional state more profoundly.

QA10. Please summarise your initial professional qualifications as a counsellor.

Organisation providing the counselling training	Length of training	full-time or part-time	Main theoretical model(s) of the training	Supervision received in hours
S1 CRUSE Bereavement Coun Adult Children	 44hrs 42hrs	PT	Person-centred, some Egan	1hr to every 3 hrs counselling
S2 CRUSE Bereavement Coun	4 months i.e. 2hrs/wk + 3x6hrs	PT	Person-centred	1:3 as trainee; 1:8 as accredited counsellor
University	1yr	PT	Person-centred	1:8
S3 University	1yr	PT	Person-centred/ Humanistic	14hrs
S4 University	1yr	PT	Person-centred Gestalt	½ hr for each 3 hrs
S5 University	1¼ yr		still in training	
S6 University	1yr + 1 term	PT	Person-centred/ Humanistic	10
S7 RSA University	1yr 1yr	PT PT	none Roger/Egan	N/A N/A
S8 University	4 terms	PT	Rogerian	10
S9 University	2yrs +	PT	Humanistic	in accordance with BAC guidelines
S10 College	3yrs	PT	Client-centred	54
S11 University University Cert Stockton Psychotherapy	2yrs 1yr 1yr	PT PT PT	Egan/Humanistic Egan/Humanistic Humanistic	1½ hrs per week N/A N/A
S12 CRUSE	5 days intensive + follow up work	PT	Humanistic	N/A
S13 University	1yr	Pt	Person-centred	on-going (tutor)
S15 University	1 1/2 yrs	FT	Humanistic, child sexual abuse	N/A
S16 University	2yrs	PT	Humanistic	36
S17 DACE	2 1/2 yrs		Egan, Person-centred	15
S18 University Relate certificate in couple counselling	1yr 2yr	FT PT	Person-centred Person-centred & psychodynamic	N/A 18hrs individual 54 hrs group
S19 University	2yr	PT	Humanistic	50
S20 Cleveland course Redcar University	1yr 3yrs	PT PT	Person-centred Person-centred	15 60
S21 University	4yrs	PT	PCA	40
S24 University	2yrs	PT	Person-centred	N/A
S25 University	1yr	PT	Person-centred/ Humanistic	33 ¼
S26 University	1yr	FT	Person-centred/ Humanistic	N/A
S27 University	3yrs	PT	Person-centred	1:8

S28 Stockton Psychotherapy	36 wks	PT	Person-centred Problem solving	20hrs
S30 University College	3yrs 1yr	PT PT	Person-Centred Person-Centred	36hrs N/A
S31 National marriage guidance council (now known as relate)	2yrs	PT	Person-centred Psychodynamic	1½ hr/month 1 to 1 and group supervision
S32 University (clinical psychology)	2yrs	FT	Cognitive behavioural	1hr weekly for 2yrs
S34 RELATE	2yrs	PT	Psychodynamic Humanistic	12
S35 University	3yrs	PT	Rogerian	N/A
S36 Gestalt/Growth centre University	1yr 1yr	PT PT	Gestalt Person-centred	N/A N/A
S37 Rape crisis centre	48hrs	PT	Person-centred	1hr in 8hrs counselling
S38 University	4yrs	PT	Person-centred/ Humanistic	50hrs
S39 University	2yrs	PT	Person-centred	1½-2hr per month
S40 Marriage Care initial Marriage care in-service University	1yr on going 3yrs	PT PT PT	Egan, Rogers As above and other humanistic Person-centred	10hrs 1hr to 8hrs client contact 1hr to 4hrs client contact
S41 Post-Graduate Cert. Post-Graduate Dip.	1yr 1yr	PT PT	Person-centred Person-centred	10-12 10-12
S42 DACE/CESCO Richmond Fellowship	3yrs 2yrs	PT PT	Person-centred Psychodynamic	1hr monthly 1hr weekly
S43 University	1yr	FT	Humanistic	N/A
S44 College College Post-Grad Cert. Post-Grad Dip. (current)	1yr 1yr 1yr 1yr	PT PT PT PT	Person-centred Person-centred Humanistic Humanistic	N/A 15 25 every 6 sessions
S45 MMGC (relate) College	5yrs 2yrs	PT PT	Person-centred, Psychodynamic, & Egan Egan	50 25
S48 College University	1yr 1yr	PT PT	Person-centred skill Person-centred	N/A 10
S49 Regional Dept of Psychotherapy (1974-9) University	ongoing 3yrs	PT PT	Psychodynamic Eclectic	1hr per week 1hr per week
S50 University	2yrs	PT	Humanistic	60hrs
S51 University	1yr	FT	Person-centred	can't remember
S52 Centre for Humanist psychotherapy	1yr	PT	Person-centred	30hr as group supervisor
S53 University		PT	Person-centred	36
S54 University	4yr	PT	Person-centred	90mins 4 weekly 3yrs
S55 University	1yr	PT	Humanistic	25
S56 College	1yr 1yr	PT FT	Person-centred as above	N/A 18hrs

S57 Relate University	3yrs 2yrs	PT PT	Psychodynamic Person-centred/ Humanistic	1½ hr per 6 wks 1½ hr per month
S58 University	3yrs	PT	Person-centred	N/A
S59 University	3yrs	PT	Humanistic	1½ hr per month
S61 Eigenwelt	4yrs	PT	Person-centred	at least 120
S62 College University	1yr 2½ yrs	PT PT	Person-centred Person-centred	N/A 40hrs
S63 MIND Victim support	6months 6months	PT PT	Person-centred Person-centred	3hrs 3hrs
S64 College Co-counselling community University	2yrs 16wks 2yrs	PT PT PT	Eclectic Re-evaluation coun both	N/A 16hrs 24hrs
S65 Health Authority	2yrs	FT	Cognitive-beh Psychoanalytic	1½ hr per wk over 2yrs
S66 Marriage care University	2yrs 2yrs	PT PT	Egan Person-centred	48 18
S67 Relate	3yrs	PT	Psychodynamic	1hr for every 20 hrs counselling
S68 NCFE Counselling psy course	1yr 1yr	PT PT	Humanistic Integrative	1hr per month N/A
S69 University	3yrs	PT	Person-centred	N/A
S70 University Regional psychotherapy	2yrs 3yrs	PT PT	Humanistic Psychodynamic	1hr per wk 2hrs per wk
S72 Marriage care Social work	2yrs+ 1yr	PT FT	Rogers, Egan Rogers	1½ hr per month N/A
S73 University	3yrs	PT	Person-centred	50
S75 University	1yr	PT	Person-centred	20
S76 University	1yr	FT	Person-centred/ Humanistic	N/A

QA11. Please summarise the post-qualification courses in counselling you have taken.

Organisation providing the counselling training	Length of training	full-time or part-time	Main theoretical model(s) of the training	Supervision received in hours
S1 University Certificate in counselling skills PG certificate	 1yr 1yr	PT	Person-centred	weekly during term time
S2 University PG Certificate Forget-me-not (children's bereavement)	 1yr 1yr	 PT PT	 Person-centred Person-centred	 1:8 1hr per month
S8 University	2yrs	PT	Rogerian	2hrs so far
S11Certificate in counselling supervision	1yr	PT		1½ hrs per week
S12 University	1yr	FT	Person-centred/ Humanistic	N/A

S15 Dramatherapy SSD	1yr 6 months	PT PT	Dramatherapy Child sexual abuse	10 20
S16 College Brief therapy group Certificate of crisis management	1yr 8 days 4 days	PT	model of supervision Brief therapy Trauma work	24 N/A N/A
S18 variety of short courses and workshops				
S19 BAC College	3 wks 3 wks	FT FT	Humanistic Gestalt	10 5
S20 Comm. & mental wealth trust	2 days 6 days	FT FT	Working with survivors of childhood sexual abuse Cognitive behavioural therapy	N/A N/A
S21 CRUSE	3yrs	PT	PCA	30
S31 University	1yr	PT	Person-Centred	1½hr/month 1 to 1 and group supervision
S32 Clinic NEATPP	2yrs 4yrs	PT PT	Psychodynamic Psychodynamic	1hr weekly (2yrs) 2hrs weekly(2yrs)
S37 The Albert Centre College	80hrs 5days	PT PT	N/A Egan	1 in 4 N/A
S39 NELA Many short courses & workshop	6months several per year	PT PT	Cognitive-behavioural TA,Gestalt,Solution focused, etc	N/A N/A
S48 Relate Certificate University	1½yrs 1yr	PT PT	Psychodynamic Person-centred	4 ½ hrs per mon N/A
S49 Longclose farm Developing counselling	2wks per yr 6 wks	PT PT	Grovian therapy as above	monthly workshop as above
S56 College advance diploma University	1yr 3yrs	FT PT	Person-centred Humanistic	18hrs 1½ fortnight
S59 Bereavement	3months	PT	Humanistic	1½ hr per month
S61 University Norman Vangltan	3yrs 1yr	PT PT	Humanistic Hypnotherapy	N/A 10-20hrs
S65 University	2full days + 12½ days	PT	Psychodynamic	
S67 mental health trust University	2yrs 1yr	PT FT	Psychodynamic Humanistic	40 N/A
S68 University	2yrs	PT	Humanistic	1 to 4
S72 University	1yr	PT	Rogers, Egan	2hrs per month
S73 University	3days	PT	Solution focused	N/A

Question B1: Others

	Very useful	Useful	Not very useful	Of very limited use
coming to terms with diagnosis	1			
coping with loss of job and income	1			
coping with religious teachings and beliefs		1		
dealing with anger	1			
informing employer or not	1			

Question B2: The role of counsellors in the context of HIV/AIDS: Others (n =)

Counsellors would perceive their own role as:	
counsellor	2
spiritual support	1
supporter	2
The funding agency would perceive the counsellor's role as:	
counsellor	2
supporter	1
asscessor	1
Clients would perceive the counsellors' role as:	
counsellor	2
friend	2
supporter	1

Question B4: Others (n = 8)

	Strongly agree	Agree	Disagree	Strongly disagree
facing ethical dilemma		1		
helping to come to terms with diagnosis	1			
helping to come to terms with the uncertainty of life span that left	1			
helping to prioritise and manage the time clients have left	1			
helping to work through anger	1			
helping them explore spiritual issues		1		
keeping clear boundaries as counsellor/client, and counsellor and their 'helper'		1		
offering core conditions of person centred approach	1			

Question B7: Clients without HIV/AIDS having concerns about HIV/AIDS (n = 33)

Concern about telling family and friends if infected by HIV	1
Concern about being refused by society if infected by HIV	1
Concern about loss of job if infected by HIV	1
Concern about religious beliefs if infected by HIV	1
Continuation of drug use	1
Availability of practical help	1
Partner has died of AIDS related illness	1
Treatment effectiveness	1
Waiting for the test results	1
Partner/relative with HIV:	
feelings of hurt associated with partner's lack of consideration - putting them and family at risk	1
anger, grief, fear in relation to infected partner/relative	1
Unprotected sex: (n = 5)	
unprotected sex especially in older/middle age group	1
unsafe sexual practise	1
one night stands	1
using unprotected sex as a form of self harming	1
unprotected sexual encounter and anxieties	1
Women's concern: (n=2)	
divorced women entering new relationships	1
sexual transmission	1
Rape: (n = 2)	
women having been raped	2
men having been raped	1
Having been sexually abused	3
Pre-HIV testing	2
Whether to go for testing	1
Issues around safer sex: (n = 2)	
pressures from peers to have unsafe sex	1
what forms of female contraception are "safe"	1
Concern over whether to test clients with HIV/AIDS phobia	1
Concern for the possibility of contracting HIV: (n = 21)	
possibility of being infected in the future	2
fear of having contracted HIV	6
fear of infection because of infidelity	1
fear of infection because of lifestyle	2
Gay lifestyle	3
fear of contacting HIV from sources other than from direct contact with body fluids	1
discovering a sexual partner was infected	2
having had a relationship with an IV injecting drug user	1
accidental skin injury	1
possible infection from needle-stick injury	1
awareness of risks they were taking	1
Fear of the progression of the disease: (n = 4)	
what it might lead to e.g. dementia	1
identifying signs and symptoms	1
identifying course and implications of HIV/AIDS	1
going to die	1

Question C5: Seven respondents, who have had accepted referrals of clients with HIV/AIDS for reasons other than HIV/AIDS, reported 9 issues.

	Number of respondents
Rape	1
Shock at admitting own sexuality	1
Sexual abuse	1
Wish to stop being promiscuous	1
Child prostitute	1
Hospice care	1
Distressed sister	1
Loss of job	1
Bereavement	1

QB8

S8 The role of counsellor is multifunctional. It will not just be enough to "listen" - the counsellor must be "up to date" on all the information related to the condition (including other support systems etc.)

S16 (1) I am not comfortable with tick box responses. With some I can be completely value neutral & non-directive, and with others I feel I must challenge their values.
(2) I work as a chaplain: sometimes I can be entirely in counselling mode; at other times in Pastoral care mode which includes use of counselling skills exploring practical issues, and possibly spiritual and ethical issues.

S17 (1) A need to be humble and realise they need more training than is ever offered and to sort out (in the UK in particular) their attitudes to sexuality issues.
(2) they should become aware of cross culture issues, religious prejudices, funeral routs and the importance of honest, open grieving with partners.
(3) They should be willing to work with partners and parents of people with HIV/AIDS. These people provide one with more challenge, sometimes, than PWA.

S18 (1) I think specific training is needed for this and although I feel useful work can be done using a person-centred approach, a counsellor needs extra-knowledge e.g. of pre and post test issues.
(2) I would normally refer a client on to a counsellor with special training but have occasionally counselled a client when referral was not possible.

S19 (1) Difficult to answer the questions as all relationships are unique, so not black/white answers.
(2) In this work I would see the role of information giving and some work ensuring welfare of client as important - I do not normally see this as the counsellors' role but would/do see how information (not advice) would be of great importance to the client. Important for counsellor to have knowledge of HIV/AIDS.

S20 (1) Need for good and frequent supervision - emotional load can be great on counsellors
(2) A good working knowledge of treatment of HIV/AIDS and medical knowledge of effects and symptoms.

S24 (1) Has raised for me some specific issues such as boundaries of acceptance and confidentiality

S25 (1) I think, speaking personally, I would find it extremely difficult if someone was so irresponsible to blatantly go ahead and have sex with someone, knowing they have HIV/AIDS.

S26 (1) I believe since HIV/AIDS is a life-threatening issue, not only to the client but to those around the client, that the counsellor must not allow any harm come to a third party.

S27 My lack of experience in this area, and thinking stimulated by questionnaire, has made me realise the importance of clarity of counsellor values and match to setting policies regarding risks to third parties, of which I need reading, work shop discussion to feel reasonably confident to work with these issues. Thank you, this has helped me to think around the counselling issues

regarding HIV/AIDS.

S33 I think the possible conflict between responsibility to the client and the values of the counsellor (regarding preventing the further spread of HIV/AIDS) is a big issue. I'm not sure I could continue to counsel a client who was deliberately infecting other people.

S38 I have tried to answer the questions as a Person-centred /humanistically trained counsellor, counselling is a contractional setting. My answers may well be different if my relationship with the client was different i.e. in role of a chaplain or simply using counselling skills in a non-contractional relationship. I think that those living with HIV/AIDS can benefit from both kinds of response.

S39 As a counsellor I meet each 'client' as a person first, then as that person with an issue or problem. Thus my role as counsellor would be "me as counsellor to all my 'clients', and HIV/AIDS status would be no more of a 'defining' characteristic than "a person with a disability" or "a person from an ethnic minority" or "a person of ..."

S40 I feel it is difficult to counsel these people and set your values and judgements to one side.

S42 The tasks listed in B1 mix together counselling, social work and health advice voices although perhaps ideally all should be combined in one person. This ideal is only met, in my experience, in dedicated HIV/AIDS agencies.

S44 I have been a volunteer with an HIV/AIDS project.

S48 I would not like to have to make all these kinds of decisions.

S50 (1) It is a very difficult topic to work with. I think counsellors should have the o opportunity to explore their own values/attitudes on HIV/AIDS.
(2) I think HIV/AIDS training should be in counselling training - even at a basic level, it would increase awareness.

S52 I want to establish a healthy relationship based on the principles of the person centred therapy that I believe in.

S53 (1) I think it should be a special role, in order to incorporate information giving, if it is in a special unit for the purpose of providing support for HIV/AIDS persons.
(2) If I saw someone in the primary care setting I would give them the same support as any other person suffering from a long term terminal illness and would ensure they had appropriate information and back up from other support services.

S54 (1) It may be difficult to work as a 'pure' counsellor within this speciality as the client often requires information referring to their diagnosis. Hence there may be a cross-over to adviser to meet that need.
(2) Clients do not necessarily have a clear understanding of what counselling is. A counsellor needs to have a lot of inside knowledge. My experience shows this works best for clients. They don't want to have to go somewhere else for that information. Trust & rapport builds quickly if they perceive you as knowledgeable about their condition. They don't want to have to start educating the counsellor.

S61 I have not worked with a person with HIV/AIDS. My completion of the questionnaire is based on relevant experience and thinking about the issues in relation to relevant experience.

S62 (1) I have never counselled a person with HIV/AIDS and before doing so I would like training in this particular topic.
(2) Completing this questionnaire has raised many ethical dilemmas for me and the answers I have given may change in time and with training and discussion.

S66 Every client will have a different need. Although I feel that it may be difficult for counsellors to be value-neutral or value-free in the context of HIV/AIDS, I am aware that it may be a pre-requisite for counselling clients who will be extra-sensitive at "picking-up" the values of the counsellor. It is very challenging.

S67 Found it difficult to answer yes or no, e.g. nos 5 & 6.

S72 I believe that because of stigma attached to HIV/AIDS and clients' need for secrecy and families' need for support, it is harder for clients to seek relevant help from other agencies. Therefore I think the counsellor's role is extended to more information giving and liaison with other services than in other forms of counselling.

S75 I have no personal experience so many issues raised in the questionnaire are not ones I have thought out deeply for myself.

Appendix 9.3: Frequency tables

Table 1: Personal characteristics of all respondents (Questions A1 to A6)

		Number of respondents (%)
Status of respondents (n = 76)		
Experienced counsellor	30	(39.5%)
Student	46	(60.5%)
Profession (n = 76)		
Counsellor	33	(43.4%)
Trainee counsellor	23	(30.3%)
Trainee counsellor undertaking placement	9	(11.8%)
Others	11	(14.5%)
Sex (n = 75)		
Female	63	(84%)
Male	12	(16%)
Age (n = 76)		
21-25	3	(3.9%)
26-30	4	(5.3%)
31-35	6	(7.9%)
36-40	8	(10.5%)
over 40	55	(72.4%)
Length of counselling experience (n = 76)		
none	7	(9.2%)
under 3 months	2	(2.6%)
3-6 months	1	(1.3%)
7-12 months	5	(6.6%)
over 1 year	3	(3.9%)
2-5 years	21	(27.6%)
6-10 years	15	(19.7%)
11-15 years	6	(7.9%)
16-20 years	9	(11.8%)
over 20 years	7	(9.2%)
Highest qualification (n = 76)		
BA/BSc	4	(5.5%)
Certificate in Counselling Skills	15	(20.5%)
Postgraduate Certificate	18	(24.7%)
Postgraduate Diploma	15	(20.5%)
MA/MSc	20	(27.4%)
PhD	1	(1.4%)
Accredited counsellor (n = 76)		
Yes	13	(17.1%)
No	63	(82.9%)
Working experience with clients with HIV/AIDS (n = 76)		
Yes	15	(19.7%)
No	61	(80.3%)

Table 2: Level of adequacy respondents felt that their training had prepared them (n = 72) (Question A7)

Counselling training model(s) respondents have received	Number of subjects very adequate (4)	adequate (3)	inadequate (2)	very inadequate (1)	mean	SD
Bereavement (n = 56)	17	28	6	5	3.02	0.88
Cognitive Behavioural (n = 35)	2	12	17	4	2.34	0.76
Gestalt (n = 41)	3	14	16	8	2.29	0.87
Person-Centred/Humanistic (n = 70)	31	25	9	5	3.17	0.92
Psychodynamic (n = 29)	4	16	8	1	2.79	0.73
Rational Emotive (n = 21)	0	4	13	4	2.00	0.63
Systemic (n = 15)	1	1	12	1	2.13	0.64

SD = Standard Deviation

Table 3: Respondents' preferred model for counselling people with HIV/AIDS and the best model, and their reasons for this choice (Questions A8 and A9)

Preferred model (n = 7)	
Person-Centred/Humanistic	60 (78.9%)
Psychodynamic	4 (5.3%)
Gestalt	2 (2.6%)
Cognitive behaviour	1 (1.3%)
Systemic	1 (1.3%)
Others	5 (6.6%)
Reasons for this preference (n = 76)	
the model fits my personality and/or values	61 (80.3%)
the model has good research support	17 (22.4%)
the model is logical	10 (13.2%)
the choice of this model is based on the orientation of my supervisor	6 (7.9%)
the choice of this model is based on my clinical experience	33 (43.4%)
the choice of this model is based on the counselling training I have received	58 (76.3%)
others	4 (5.3%)
Best model (n = 66)	
Person-Centred/Humanistic	54 (81.8%)
Cognitive behaviour	2 (3%)
Gestalt	2 (3%)
Psychodynamic	1 (1.5%)
Systemic	1 (1.5%)
Others	6 (9.1%)

Table 4: The usefulness of counselling in dealing with the problems frequently associated with HIV/AIDS clients (n = 76) (Question B1)

Frequent problems associated with HIV/AIDS	4	3	2	1	*	mean	SD
(1) Anxiety about death	54	19	1	1	1	3.68	0.57
(2) Anxiety in general	50	23	1	0	2	3.66	0.50
(3) Caring for children with or without HIV/AIDS	22	36	11	3	4	3.07	0.79
(4) Coming off drugs	20	39	9	4	4	3.04	0.80
(5) Coping with bereavement(s)	59	16	0	0	1	3.79	0.41
(6) Coping with physical pains	7	37	21	8	3	2.59	0.81
(7) Depression	40	33	2	0	1	3.51	0.55
(8) Difficulty in social relationships	37	36	1	0	2	3.49	0.53
(9) Disease progression and loss of control	26	35	9	4	2	3.12	0.83
(10) Eating disorders	25	40	6	3	2	3.18	0.75
(11) Family problems	41	34	0	0	1	3.55	0.50
(12) Feeling of guilt	46	29	0	0	1	3.61	0.49
(13) Furniture/household appliances	1	6	27	40	2	1.57	0.70
(14) Having a normal life	22	39	11	2	2	3.09	0.74
(15) HIV antibody testing (positive results)	42	22	6	3	3	3.41	0.81
(16) Housing	2	13	29	31	1	1.81	0.82
(17) Immigration/visas	1	9	26	39	1	1.63	0.75
(18) Informing family or sexual partner of HIV status	35	34	2	3	2	3.36	0.73
(19) Immediate health needs	12	24	30	8	2	2.54	0.89
(20) Income support and other financial benefits	4	8	30	33	1	1.77	0.85
(21) Legal problems	3	8	30	32	3	1.75	0.81
(22) Loss of health	30	33	8	3	2	3.22	0.80
(23) Loss of self-esteem and self-image	58	15	1	0	2	3.77	0.45
(24) Night sitting when ill	5	8	23	36	4	1.75	0.92
(25) Payment of bills	0	7	21	46	2	1.47	0.67
(26) Preparation for death of self (partner or child)	57	17	0	0	2	3.77	0.42
(27) Relationship problems	54	21	0	0	1	3.72	0.45
(28) Reproduction decision	34	37	2	1	2	3.41	0.62
(29) Sexual problems	34	38	2	1	1	3.40	0.62
(30) Sleep disorders	17	38	17	2	2	2.95	0.76
(31) Stress	47	28	0	0	1	3.63	0.49
(32) Suicidal ideations/attempts	49	25	0	1	1	3.63	0.56
(33) Support in crises	43	23	6	1	3	3.48	0.71
(34) Transport arrangements	0	6	19	50	1	1.41	0.64
(35) 24 hour-7 day a week home care	0	8	20	45	3	1.49	0.69
(36) Uncertainty about others' reactions	34	36	1	1	4	3.43	0.60
(37) Uncertainty about the baby's HIV status	26	31	11	5	3	3.07	0.89
(38) Uncertainty about the future	43	28	4	0	1	3.52	0.60
(39) Uncertainty about treatments	24	25	20	4	3	2.95	0.91
(40) Welfare of children and family	17	29	19	7	4	2.78	0.92

4 = very useful 3 = useful 2 = not very useful 1 = of very limited use
"*" = Missing number SD = Standard Deviation

Table 5: Exploring respondents' attitudes and values in working with HIV/AIDS clients (n = 76)(Question B3)

	4	3	2	1	*	mean	SD
(a) If the counsellor knows that an antibody positive person continues unprotected sexual activity with an unsuspecting partner.							
Counsellors would accept the client's right to do so.	1	25	29	19	2	2.11	0.80
Counsellors should permit the client to make choices according to the client's own values.	6	36	25	8	1	2.53	0.79
Counsellor should not overlook the client's responsibility in preventing further infections to others and further deaths.	34	37	2	2	1	3.37	0.67
Counsellor should use all possible means to persuade clients not to place other lives at risk.	30	23	19	4	0	3.04	0.93
Counsellor should use all possible means to protect the third party.	15	24	26	10	1	2.59	0.96
(b) If the counsellor knows that an antibody positive person goes abroad to sell blood, plasma, sperm, or even organs; or sharing needles with other drug users.							
Counsellors would accept the client's right to do so.	1	16	35	21	3	1.96	0.75
Counsellors should permit the client to make choices according to the client's own values.	4	29	28	12	3	2.34	0.82
Counsellor should not overlook the client's responsibility in preventing further infections to others and further deaths.	33	37	2	2	2	3.36	0.67
Counsellor should use all possible means to persuade clients not to place other lives at risk.	28	32	12	2	2	3.16	0.79
Counsellor should use all possible means to protect the third party.	20	29	22	4	1	2.87	0.88
(c) If the counsellor knows that an antibody positive women decides to risk the possibility of vertical transmission and decides to get pregnant.							
Counsellors would accept the client's right to do so.	2	40	22	9	3	2.48	0.75
Counsellors should permit the client to make choices according to the client's own values.	5	42	21	6	2	2.62	0.73
Counsellor should not overlook the client's responsibility in preventing further infections to others and further deaths.	22	46	4	2	2	3.19	0.66
Counsellor should use all possible means to persuade clients not to place other lives at risk.	19	37	13	4	3	2.97	0.82
Counsellor should use all possible means to protect the third party.	15	28	25	5	3	2.73	0.87

4 = strongly agree 3 = agree 2 = disagree 1 = strongly disagree
* = Missing number SD = Standard Deviation

Table 6: The aim of counselling people with HIV/AIDS (n = 76) (Question B4)

	4	3	2	1	*	mean	SD
(1) making sure that clients know how to reach the counsellor in case of difficulty	15	48	9	2	2	3.03	0.66
(2) being approachable	48	27	1	0	0	3.62	0.52
(3) being caring	54	19	3	0	0	3.67	0.55
(4) being directive	1	10	47	16	2	1.95	0.64
(5) listening carefully to clients' responses and helping them to talk through what HIV/AIDS means to them	68	8	0	0	0	3.89	0.31
(6) being non-directive	26	36	11	0	3	3.21	0.69
(7) providing information about infection control issues	16	37	19	1	3	2.93	0.73
(8) being sensitive to client's needs	62	14	0	0	0	3.82	0.39
(9) being understanding	64	12	0	0	0	3.84	0.37
(10) encouraging clients to prepare for death	12	38	23	1	2	3.82	0.71
(11) encouraging clients to take positive steps to maintain and improve general health	29	32	12	1	2	3.20	0.76
(12) having good networks with other professionals	39	33	4	0	0	3.46	0.60
(13) helping clients to arrange a social support network or to make the best use of them	23	36	13	1	3	3.11	0.74
(14) helping clients to deal with relationship issues	38	35	2	0	1	3.48	0.56
(15) helping clients to decide who else they wished to tell about their HIV status	39	33	2	0	2	3.50	0.56
(16) helping clients to adopt safer sex practice	27	30	14	0	5	3.18	0.74
(17) being accepting	65	10	1	0	0	3.84	0.40
(18) providing facts about HIV/AIDS	19	32	21	1	3	2.95	0.78
(19) helping client with practical problems such as housing, welfare benefits, etc.	0	18	37	18	3	2.00	0.71
(20) being non-judgmental	65	10	1	0	0	3.84	0.40
(21) informing clients about what hospital and voluntary services are available and how to access them	13	42	16	2	3	2.90	0.71
(22) improving clients' self-concept and self-esteem	54	20	1	0	1	3.71	0.49
(23) helping clients to reduce other risk factors	25	33	13	1	4	3.14	0.76
(24) being supportive	57	16	2	1	0	3.70	0.59
(25) preventing the spread of HIV infection and AIDS	14	25	22	11	4	2.58	0.98
(26) being friendly	22	31	17	5	1	2.93	0.89
(27) promoting behaviour and attitude change	9	29	31	3	4	2.61	0.76
(28) making sure that clients have adequate medical support and services	10	32	30	2	2	2.68	0.74
(29) reducing anxiety and depression	40	28	6	0	2	3.46	0.65
(30) helping clients to inform sexual partners	27	33	13	0	3	3.19	0.72
(31) showing empathy	64	11	0	1	0	3.82	0.48
(32) providing facts about transmission	14	34	20	4	4	2.81	0.82

4 = strongly agree 3 = agree 2 = disagree 1 = strongly disagree
"*" = Missing number SD = Standard Deviation

Table 7: Respondents' opinions towards value disclosure (Questions B5 to B7)

	Number of respondents
In order to be honest, counsellors should be willing to disclose their own values in counselling settings (n = 70)	
Yes	52
No	18
Counsellors are able to be value-neutral or value-free in the context of HIV/AIDS (n = 73)	
Yes	15
No	58

Table 8 Respondents' counselling experience with HIV/AIDS clients (n = 15) (Questions C1 to C5)

	Number of respondents
Length of counselling experience with HIV/AIDS clients	
under 3 months	4
3-6 months	1
over 1 year	1
2-5 years	4
6-10 years	4
11-15 years	1
Having accepted referrals of clients with HIV/AIDS from other agencies	
Yes	7
No	8
Having had experience counselling people with HIV/AIDS in which the clients were not initially aware of their HIV status	
Yes	7
No	8
Having had experience counselling people with HIV/AIDS without being aware of their HIV status	
Yes	7
No	8
Having had accepted referrals of clients with HIV/AIDS for reasons other than HIV/AIDS	
Yes	8
No	7
Number of HIV/AIDS clients seen	
under 6	8
6-10	3
16-20	1
26-30	1
31-35	1

Appendix 9.4: Data analysis

Question A7

Table 9: Models of counselling training experienced counsellors and students received crosstabulation (n = 76)

Model of counselling		Experienced counsellors	Student	Total	Chi-square	p
Bereavement	No	6	14	20	1.020	0.313
	Yes	24	32	56		
	Total	30	46	76		
Person-centred/Humanistic	No	3	3	6	*	N/A
	Yes	27	43	70		
	Total	30	46	76		
Cognitive behaviour	No	14	27	41	1.058	0.304
	Yes	16	19	35		
	Total	30	46	76		
Gestalt	No	16	19	35	1.058	0.304
	Yes	14	27	41		
	Total	30	46	76		
Psychodynamic	No	17	30	47	0.563	0.453
	Yes	13	16	29		
	Total	30	46	76		
Rational emotive	No	22	33	55	0.023	0.879
	Yes	8	13	21		
	Total	30	46	76		
System	No	23	38	61	0.450	0.525
	Yes	7	8	15		
	Total	30	46	76		

* 2 cells (50%) have expected count less than 5.

Table 10: Level of adequacy respondents felt that their training had prepared them: The perceptions of experienced counsellors and students (n = 70)

Models	Status	Number of respondents	Mean	t	p
Bereavement	Experienced counsellor	24	3.13	0.783	0.437
	Student	32	2.94		
Cognitive Behavioural	Experienced counsellor	16	2.50	1.120	0.271
	Student	19	2.21		
Gestalt	Experienced counsellor	14	2.50	1.098	0.279
	Student	27	2.19		
Person-Centred/ Humanistic	Experienced counsellor	27	3.33	1.175	0.244
	Student	43	3.07		
Psychodynamic	Experienced counsellor	13	3.00	1.407	0.171
	Student	16	2.63		
Rational Emotive	Experienced counsellor	8	1.75	1.461	0.160
	Student	13	2.15		
Systemic	Experienced counsellor	7	2.43	1.800	0.095
	Student	8	1.88		
All items	Experienced counsellor	27	2.66	0.852	0.411
	Student	43	2.44		

Table 11: Level of adequacy respondents felt that their training had prepared them: The perceptions of female and males (n = 69)

Models	Sex	Number of respondents	Mean	t	p
Bereavement	Female	46	2.96	1.163	0.250
	Male	9	3.33		
Cognitive Behavioural	Female	25	2.24	1.441	0.159
	Male	9	2.67		
Gestalt	Female	35	2.34	0.809	0.424
	Male	5	2.00		
Person-Centred/ Humanistic	Female	57	3.16	0.312	0.756
	Male	12	3.25		
Psychodynamic	Female	25	2.72	1.383	0.179
	Male	3	3.33		
Rational Emotive	Female	19	2.05	0.083	0.935
	Male	1	2.00		
Systemic	Female	12	2.17	0.318	0.756
	Male	2	2.00		
All items	Female	57	2.52	0.456	0.657
	Male	12	2.65		

Table 12: Level of adequacy respondents felt that their training had prepared them: The perceptions of respondents ≤ 40 and > 40 years old (n = 70)

Models	Age	Number of respondents	Mean	t	p
Bereavement	≤ 40 years old	14	2.93	0.443	0.667
	> 40 years old	42	3.05		
Cognitive Behavioural	≤ 40 years old	10	2.50	0.764	0.450
	> 40 years old	25	2.28		
Gestalt	≤ 40 years old	11	2.55	1.126	0.267
	> 40 years old	30	2.20		
Person-Centred/ Humanistic	≤ 40 years old	21	3.10	0.453	0.652
	> 40 years old	49	3.20		
Psychodynamic	≤ 40 years old	10	2.70	0.494	0.625
	> 40 years old	19	2.84		
Rational Emotive	≤ 40 years old	9	2.22	1.430	0.169
	> 40 years old	12	1.83		
Systemic	≤ 40 years old	7	2.14	0.052	0.959
	> 40 years old	8	2.13		
All items	≤ 40 years old	21	2.59	0.367	0.720
	> 40 years old	49	2.50		

Table 13: Level of adequacy respondents felt that their training had prepared them: The perceptions of respondents' cousnelling experience in years (n = 70)

Models	Length of counselling experience in years	Number of respondents	Mean	t	p
Bereavement	None to over 5 years	25	2.96	0.437	0.664
	6 to over 20 years	31	3.06		
Cognitive Behavioural	None to over 5 years	16	2.13	1.580	0.124
	6 to over 20 years	19	2.53		
Gestalt	None to over 5 years	22	2.18	0.872	0.388
	6 to over 20 years	19	2.42		
Person-Centred/ Humanistic	None to over 5 years	37	3.08	0.872	0.386
	6 to over 20 years	33	3.27		
Psychodynamic	None to over 5 years	16	2.56	1.996	0.056
	6 to over 20 years	13	3.08		
Rational Emotive	None to over 5 years	11	2.09	0.682	0.504
	6 to over 20 years	10	1.90		
Systemic	None to over 5 years	8	1.88	1.800	0.095
	6 to over 20 years	7	2.43		
All items	None to over 5 years	37	2.41	1.020	0.328
	6 to over 20 years	33	2.67		

Table 14: Level of adequacy respondents felt that their training had prepared them: The perceptions of respondents having or having not had working experience with clients with HIV/AIDS (n = 70)

Models	Working with clients with HIV/AIDS	Number of respondents	Mean	t	p
Bereavement	No	44	3.00	0.287	0.775
	Yes	12	3.08		
Cognitive Behavioural	No	25	2.20	1.804	0.080
	Yes	10	2.70		
Gestalt	No	34	2.24	0.926	0.360
	Yes	7	2.57		
Person-Centred/ Humanistic	No	57	3.14	0.591	0.556
	Yes	13	3.31		
Psychodynamic	No	23	2.74	0.778	0.443
	Yes	6	3.00		
Rational Emotive	No	14	2.00	0.000	1.000
	Yes	7	2.00		
Systemic	No	10	2.00	1.155	0.269
	Yes	5	2.40		
All items	No	57	2.47	1.005	0.335
	Yes	13	2.72		

Questions A8 and A9

Table 15: Reasons for the choice of the preferred model: the perceptions of respondents

Status		Experienced counsellor	Student	Total	chi-square	p
(1) The model fits my personality and/or values	Yes	25	36	61	0.295	0.587
	No	5	10	15		
	Total	30	46	76		
(2) The model has good research support	Yes	8	9	17	0.527	0.468
	No	22	37	57		
	Total	30	46	76		
(5) The choice of this model is based on my clinical experience	Yes	17	16	33	3.540	0.060
	No	13	30	43		
	Total	30	46	76		
(6) The choice of this model is based on the counselling training I have received	Yes	22	36	58	0.244	0.621
	No	8	10	18		
	Total	30	46	76		
Counselling experience		0 to 5+ years	6 to 20+ years	Total	chi-square	p
(1) The model fits my personality and/or values	Yes	29	32	61	1.763	0.184
	No	10	5	15		
	Total	39	37	76		
(2) The model has good research support	Yes	8	9	17	0.159	0.690
	No	31	28	59		
	Total	39	37	76		
(5) The choice of this model is based on my clinical experience	Yes	12	21	33	5.219	**0.022**
	No	27	16	43		
	Total	39	37	76		
(6) The choice of this model is based on the counselling training I have received	Yes	30	28	58	0.016	0.898
	No	9	9	18		
	Total	39	37	76		

Note: Only more than 80% of the cells contained at least 5 cases were calaulated.

Question B1

Group 1. Psychological health

Table 16: The usefulness of counselling in dealing with clients' psychological health: The perceptions of experienced counsellors and students (n = 75)

	Status	Number of respondents	Mean	t	p
(23) Loss of self-esteem and self-image	Experienced counsellor	29	3.66	1.773	0.080
	Student	45	3.84		
(32) Suicidal ideations/attempts	Experienced counsellor	30	3.47	2.049	**0.044**
	Student	45	3.73		
(2) Anxiety in general	Experienced counsellor	29	3.55	1.526	0.131
	Student	45	3.73		
(12) Feeling of guilt	Experienced counsellor	30	3.50	1.654	0.102
	Student	45	3.69		
(31) Stress	Experienced counsellor	30	3.47	2.397	**0.019**
	Student	45	3.73		
(33) Support in crises	Experienced counsellor	28	3.29	1.873	0.065
	Student	45	3.60		
(7) Depression	Experienced counsellor	30	3.37	1.818	0.074
	Student	45	3.60		
All items	Experienced counsellor	30	3.47	4.165	**0.001**
	Student	45	3.70		

Table 17: The usefulness of counselling in dealing with clients' psychological health: The perceptions of males and females (n = 74)

	Sex	Number of respondents	Mean	t	p
(23) Loss of self-esteem and self-image	Female	61	3.75	0.546	0.587
	Male	12	3.83		
(32) Suicidal ideations/attempts	Female	62	3.61	0.299	0.766
	Male	12	3.67		
(2) Anxiety in general	Female	61	3.69	0.662	0.510
	Male	12	3.58		
(12) Feeling of guilt	Female	62	3.65	0.942	0.349
	Male	12	3.50		
(31) Stress	Female	62	3.63	0.295	0.769
	Male	12	3.58		
(33) Support in crises	Female	60	3.48	0.294	0.769
	Male	12	3.42		
(7) Depression	Female	62	3.52	0.565	0.574
	Male	12	3.42		
All items	Female	62	3.62	0.720	0.485
	Male	12	3.57		

Table 18: The usefulness of counselling in dealing with clients' psychological health: The perceptions of respondents age ≤ 40 and > 40 years old (n = 75)

	Age	Number of respondents	Mean	t	p
(23) Loss of self-esteem and self-image	≤ 40 years old	21	3.76	0.099	0.921
	> 40 years old	53	3.77		
(32) Suicidal ideations/attempts	≤ 40 years old	21	3.57	0.526	0.600
	> 40 years old	54	3.65		
(2) Anxiety in general	≤ 40 years old	21	3.43	2.607	**0.011**
	> 40 years old	53	3.75		
(12) Feeling of guilt	≤ 40 years old	21	3.52	0.986	0.327
	> 40 years old	54	3.65		
(31) Stress	≤ 40 years old	21	3.57	0.610	0.544
	> 40 years old	54	3.65		
(33) Support in crises	≤ 40 years old	21	3.48	0.025	0.980
	> 40 years old	52	3.48		
(7) Depression	≤ 40 years old	21	3.67	1.574	0.120
	> 40 years old	54	3.44		
All items	≤ 40 years old	21	3.57	1.242	0.238
	> 40 years old	54	3.77		

Table 19: The usefulness of counselling in dealing with clients' psychological health: The perception between counselling experience under and over 6 years (n = 72)

	Length of counselling experience in years	Number of respondents	Mean	t	p
(23) Loss of self-esteem and self-image	None to over 5 years	39	3.79	0.489	0.627
	6 to over 20 years	35	3.74		
(32) Suicidal ideations/attempts	None to over 5 years	39	3.64	0.228	0.820
	6 to over 20 years	36	3.61		
(2) Anxiety in general	None to over 5 years	39	3.67	0.081	0.936
	6 to over 20 years	35	3.66		
(12) Feeling of guilt	None to over 5 years	39	3.67	0.980	0.330
	6 to over 20 years	36	3.56		
(31) Stress	None to over 5 years	39	3.72	1.712	0.091
	6 to over 20 years	36	3.53		
(33) Support in crises	None to over 5 years	39	3.56	1.094	0.278
	6 to over 20 years	34	3.38		
(7) Depression	None to over 5 years	39	3.64	2.243	**0.028**
	6 to over 20 years	36	3.36		
All items	None to over 5 years	39	3.67	2.045	0.063
	6 to over 20 years	36	3.55		

Table 20: The usefulness of counselling in dealing with clients' psychological health: The perceptions of respondents having or having not had working experience with clients with HIV/AIDS (n = 75)

	Working with clients with HIV/AIDS	Number of respondents	Mean	t	p
(23) Loss of self-esteem and self-image	No	60	3.78	0.509	0.612
	Yes	14	3.71		
(32) Suicidal ideations/attempts	No	60	3.68	1.765	0.082
	Yes	15	3.40		
(2) Anxiety in general	No	60	3.67	0.158	0.875
	Yes	14	3.64		
(12) Feeling of guilt	No	60	3.68	2.565	**0.012**
	Yes	15	3.33		
(31) Stress	No	60	3.67	1.433	0.156
	Yes	15	3.47		
(33) Support in crises	No	60	3.53	1.404	0.165
	Yes	13	3.23		
(7) Depression	No	60	3.55	1.362	0.178
	Yes	15	3.33		
All items	No	60	3.65	2.815	**0.016**
	Yes	15	3.44		

Group 2. Personal concerns

Table 21: The usefulness of counselling in dealing with clients'personal concerns: The perceptions of experienced counsellors and students (n = 75)

	Status	Number of respondents	Mean	t	p
(5) Coping with bereavement(s)	Experienced counsellor	30	3.77	0.341	0.734
	Student	45	3.80		
(26) Preparation for death of self (partner or child)	Experienced counsellor	29	3.72	0.750	0.456
	Student	45	3.80		
(1) Anxiety about death	Experienced counsellor	30	3.67	0.163	0.871
	Student	45	3.69		
(38) Uncertainty about the future	Experienced counsellor	30	3.47	0.625	0.534
	Student	45	3.56		
(15) HIV antibody testing (positive results)	Experienced counsellor	29	3.48	0.609	0.544
	Student	44	3.36		
(29) Sexual problems	Experienced counsellor	30	3.33	0.764	0.447
	Student	45	3.44		
(4) Coming off drugs	Experienced counsellor	29	2.97	0.665	0.508
	Student	43	3.09		
All items	Experienced counsellor	30	3.49	0.329	0.748
	Student	45	3.53		

Table 22: The usefulness of counselling in dealing with clients' personal concerns: The perceptions of males and females (n = 74)

	Sex	Number of respondents	Mean	t	p
(5) Coping with bereavement(s)	Female	62	3.82	1.861	0.067
	Male	12	3.58		
(26) Preparation for death of self (partner or child)	Female	61	3.77	0.151	0.880
	Male	12	3.75		
(1) Anxiety about death	Female	62	3.69	0.604	0.548
	Male	12	3.58		
(38) Uncertainty about the future	Female	62	3.53	0.169	0.866
	Male	12	3.50		
(15) HIV antibody testing (positive results)	Female	60	3.42	0.327	0.745
	Male	12	3.50		
(29) Sexual problems	Female	62	3.42	0.439	0.662
	Male	12	3.33		
(4) Coming off drugs	Female	59	3.02	0.263	0.793
	Male	12	3.08		
All items	Female	62	3.52	0.380	0.711
	Male	12	3.42		

Table 23: The usefulness of counselling in dealing with clients' personal concerns: The perceptions of respondents age ≤ 40 and > 40 years old (n = 75)

	Age	Number of respondents	Mean	t	p
(5) Coping with bereavement(s)	≤ 40 years old	21	3.71	0.947	0.347
	> 40 years old	54	3.81		
(26) Preparation for death of self (partner or child)	≤ 40 years old	21	3.67	1.332	0.187
	> 40 years old	53	3.81		
(1) Anxiety about death	≤ 40 years old	21	3.43	2.447	**0.017**
	> 40 years old	54	3.78		
(38) Uncertainty about the future	≤ 40 years old	21	3.29	2.157	**0.034**
	> 40 years old	54	3.61		
(15) HIV antibody testing (positive results)	≤ 40 years old	21	3.10	2.160	**0.034**
	> 40 years old	52	3.54		
(29) Sexual problems	≤ 40 years old	21	3.48	0.666	0.507
	> 40 years old	54	3.37		
(4) Coming off drugs	≤ 40 years old	19	3.26	1.426	0.158
	> 40 years old	53	2.96		
All items	≤ 40 years old	21	3.42	0.934	0.368
	> 40 years old	54	3.55		

Table 24: The usefulness of counselling in dealing with clients' personal concerns: The perception between counselling experience under and over 6 years (n = 72)

	Length of counselling experience in years	Number of respondents	Mean	t	p
(5) Coping with bereavement(s)	None to over 5 years	39	3.77	0.379	0.706
	6 to over 20 years	36	3.81		
(26) Preparation for death of self (partner or child)	None to over 5 years	39	3.77	0.022	0.982
	6 to over 20 years	35	3.77		
(1) Anxiety about death	None to over 5 years	39	3.64	0.610	0.544
	6 to over 20 years	36	3.72		
(38) Uncertainty about the future	None to over 5 years	39	3.56	0.659	0.512
	6 to over 20 years	36	3.47		
(15) HIV antibody testing (positive results)	None to over 5 years	39	3.41	0.098	0.994
	6 to over 20 years	34	3.41		
(29) Sexual problems	None to over 5 years	39	3.49	1.283	0.204
	6 to over 20 years	36	3.31		
(4) Coming off drugs	None to over 5 years	37	3.14	1.026	0.308
	6 to over 20 years	35	2.94		
All items	None to over 5 years	39	3.54	0.347	0.734
	6 to over 20 years	36	3.49		

Table 25: The usefulness of counselling in dealing with clients' personal concerns: The perceptions of respondents having or having not had working experience with clients with HIV/AIDS (n = 75)

	Working with clients with HIV/AIDS	Number of respondents	Mean	t	p
(5) Coping with bereavement(s)	No	60	3.80	0.557	0.579
	Yes	15	3.73		
(26) Preparation for death of self (partner or child)	No	60	3.82	1.990	**0.050**
	Yes	14	3.57		
(1) Anxiety about death	No	60	3.70	0.602	0.549
	Yes	15	3.60		
(38) Uncertainty about the future	No	60	3.55	0.863	0.391
	Yes	15	3.40		
(15) HIV antibody testing (positive results)	No	58	3.40	0.296	0.768
	Yes	15	3.47		
(29) Sexual problems	No	60	3.45	1.417	0.161
	Yes	15	3.20		
(4) Coming off drugs	No	57	2.98	1.237	0.220
	Yes	15	3.27		
All items	No	60	3.53	0.501	0.626
	Yes	15	3.46		

Group 3. Children and family

Table 26: The usefulness of counselling in dealing with clients' concerns for children and family: The perceptions of experienced counsellors and students (n = 75)

	Status	Number of respondents	Mean	t	p
(11) Family problems	Experienced counsellor	30	3.43	1.616	0.110
	Student	45	3.62		
(28) Reproduction decision	Experienced counsellor	29	3.41	0.093	0.926
	Student	45	3.40		
(3) Caring for children with or without HIV/AIDS	Experienced counsellor	29	2.86	1.853	0.068
	Student	43	3.21		
(37) Uncertainty about the baby's HIV status	Experienced counsellor	28	3.14	0.562	0.576
	Student	45	3.02		
(40) Welfare of children and family	Experienced counsellor	28	2.93	1.108	0.272
	Student	44	2.68		
All items	Experienced counsellor	30	3.15	0.135	0.896
	Student	45	3.18		

Table 27: The usefulness of counselling in dealing with clients' concerns for children and family: The perceptions of males and females (n = 74)

	Sex	Number of respondents	Mean	t	p
(11) Family problems	Female	62	3.58	1.040	0.302
	Male	12	3.42		
(28) Reproduction decision	Female	61	3.44	0.984	0.329
	Male	12	3.25		
(3) Caring for children with or without HIV/AIDS	Female	59	3.15	1.632	0.107
	Male	12	2.75		
(37) Uncertainty about the baby's HIV status	Female	60	3.08	0.293	0.770
	Male	12	3.00		
(40) Welfare of children and family	Female	59	2.71	1.570	0.121
	Male	12	3.17		
All items	Female	62	3.19	0.390	0.707
	Male	12	3.12		

Table 28: The usefulness of counselling in dealing with clients' concerns for children and family: The perceptions of respondents age ≤ 40 and > 40 years old (n = 75)

	Age	Number of respondents	Mean	t	p
(11) Family problems	≤ 40 years old	21	3.52	0.245	0.807
	> 40 years old	54	3.56		
(28) Reproduction decision	≤ 40 years old	21	3.19	1.919	0.059
	> 40 years old	53	3.49		
(3) Caring for children with or without HIV/AIDS	≤ 40 years old	19	2.89	1.121	0.266
	> 40 years old	53	3.13		
(37) Uncertainty about the baby's HIV status	≤ 40 years old	21	3.05	0.127	0.899
	> 40 years old	52	3.08		
(40) Welfare of children and family	≤ 40 years old	21	2.62	1.936	0.353
	> 40 years old	51	2.84		
All items	≤ 40 years old	21	3.05	1.824	0.434
	> 40 years old	54	3.22		

Table 29: The usefulness of counselling in dealing with clients' concerns for children and family: The perception between counselling experience under and over 6 years (n = 75)

	Length of counselling experience in years	Number of respondents	Mean	t	p
(11) Family problems	None to over 5 years	39	3.64	1.719	0.090
	6 to over 20 years	36	3.44		
(28) Reproduction decision	None to over 5 years	39	3.38	0.304	0.762
	6 to over 20 years	35	3.43		
(3) Caring for children with or without HIV/AIDS	None to over 5 years	36	3.11	0.443	0.659
	6 to over 20 years	36	3.03		
(37) Uncertainty about the baby's HIV status	None to over 5 years	39	3.08	0.086	0.931
	6 to over 20 years	34	3.06		
(40) Welfare of children and family	None to over 5 years	39	2.67	1.113	0.270
	6 to over 20 years	33	2.91		
All items	None to over 5 years	39	3.18	0.010	0.992
	6 to over 20 years	36	3.17		

Table 30: The usefulness of counselling in dealing with clients' concerns for children and family: The perceptions of respondents having or having not had working experience with clients with HIV/AIDS (n = 75)

	Working with clients with HIV/AIDS	Number of respondents	Mean	t	p
(11) Family problems	No	60	3.57	0.689	0.493
	Yes	15	3.47		
(28) Reproduction decision	No	59	3.41	0.038	0.970
	Yes	15	3.40		
(3) Caring for children with or without HIV/AIDS	No	57	3.09	0.379	0.706
	Yes	15	3.00		
(37) Uncertainty about the baby's HIV status	No	59	3.05	0.347	0.730
	Yes	14	3.14		
(40) Welfare of children and family	No	59	2.78	0.037	0.971
	Yes	13	2.77		
All items	No	60	3.18	0.126	0.903
	Yes	15	3.16		

Group 4. Physical health

Table 31: The usefulness of counselling in dealing with clients'physical health: The perceptions of experienced counsellors and students (n = 75)

	Status	Number of respondents	Mean	t	p
(22) Loss of health	Experienced counsellor	30	3.13	0.735	0.465
	Student	44	3.27		
(9) Disease progression and loss of control	Experienced counsellor	30	3.13	0.100	0.921
	Student	44	3.11		
(10) Eating disorders	Experienced counsellor	29	3.10	0.665	0.508
	Student	45	3.22		
(39) Uncertainty about treatments	Experienced counsellor	29	3.10	1.208	0.231
	Student	44	2.84		
(30) Sleep disorders	Experienced counsellor	29	3.03	0.806	0.423
	Student	45	2.89		
(19) Immediate health needs	Experienced counsellor	29	2.76	1.706	0.092
	Student	45	2.40		
(6) Coping with physical pains	Experienced counsellor	29	2.79	1.705	0.082
	Student	44	2.45		
(24) Night sitting when ill	Experienced counsellor	29	1.62	0.984	0.328
	Student	43	1.84		
All items	Experienced counsellor	30	2.83	0.319	0.755
	Student	45	2.75		

Table 32: The usefulness of counselling in dealing with clients' physical health: The perceptions of males and females (n = 74)

	Sex	Number of respondents	Mean	t	p
(22) Loss of health	Female	61	3.26	0.714	0.478
	Male	12	3.08		
(9) Disease progression and loss of control	Female	61	3.11	0.196	0.845
	Male	12	3.17		
(10) Eating disorders	Female	61	3.16	0.360	0.720
	Male	12	3.25		
(39) Uncertainty about treatments	Female	60	2.93	0.518	0.606
	Male	12	3.08		
(30) Sleep disorders	Female	61	3.92	0.685	0.496
	Male	12	3.08		
(19) Immediate health needs	Female	61	2.57	0.551	0.583
	Male	12	2.42		
(6) Coping with physical pains	Female	60	2.57	0.384	0.702
	Male	12	2.67		
(24) Night sitting when ill	Female	59	1.76	0.327	0.745
	Male	12	1.67		
All items	Female	62	2.91	0.367	0.719
	Male	12	2.80		

Table 33: The usefulness of counselling in dealing with clients' physical health: The perceptions of respondents age ≤ 40 and > 40 years old (n = 75)

	Age	Number of respondents	Mean	t	p
(22) Loss of health	≤ 40 years old	21	3.14	0.495	0.622
	> 40 years old	53	3.25		
(9) Disease progression and loss of control	≤ 40 years old	20	3.20	0.494	0.623
	> 40 years old	54	3.09		
(10) Eating disorders	≤ 40 years old	21	3.38	1.501	0.138
	> 40 years old	53	3.09		
(39) Uncertainty about treatments	≤ 40 years old	21	2.67	1.681	0.097
	> 40 years old	52	3.06		
(30) Sleep disorders	≤ 40 years old	21	3.00	0.385	0.702
	> 40 years old	53	2.92		
(19) Immediate health needs	≤ 40 years old	21	2.43	0.675	0.502
	> 40 years old	53	2.58		
(6) Coping with physical pains	≤ 40 years old	20	2.70	0.713	0.478
	> 40 years old	53	2.55		
(24) Night sitting when ill	≤ 40 years old	21	2.05	1.798	0.077
	> 40 years old	51	1.63		
All items	≤ 40 years old	21	2.82	0.206	0.840
	> 40 years old	54	2.77		

Table 34: The usefulness of counselling in dealing with clients' physical health: The perception between counselling experience under and over 6 years (n = 75)

	Length of counselling experience in years	Number of respondents	Mean	t	p
(22) Loss of health	None to over 5 years	39	3.15	0.707	0.482
	6 to over 20 years	35	3.29		
(9) Disease progression and loss of control	None to over 5 years	38	3.13	0.106	0.916
	6 to over 20 years	36	3.11		
(10) Eating disorders	None to over 5 years	39	3.23	0.667	0.507
	6 to over 20 years	35	3.11		
(39) Uncertainty about treatments	None to over 5 years	39	2.90	0.477	0.635
	6 to over 20 years	34	3.00		
(30) Sleep disorders	None to over 5 years	39	2.87	1.889	0.377
	6 to over 20 years	35	3.03		
(19) Immediate health needs	None to over 5 years	39	2.51	0.280	0.781
	6 to over 20 years	35	2.57		
(6) Coping with physical pains	None to over 5 years	38	2.45	1.566	0.122
	6 to over 20 years	35	2.74		
(24) Night sitting when ill	None to over 5 years	38	1.82	0.642	0.523
	6 to over 20 years	34	1.68		
All items	None to over 5 years	39	2.76	0.238	0.815
	6 to over 20 years	36	2.82		

Table 35: The usefulness of counselling in dealing with clients' physical health: The perceptions of respondents having or having not had working experience with clients with HIV/AIDS (n = 75)

	Working with clients with HIV/AIDS	Number of respondents	Mean	t	p
(22) Loss of health	No	59	3.29	1.551	0.125
	Yes	15	2.93		
(9) Disease progression and loss of control	No	59	3.15	0.635	0.527
	Yes	15	3.00		
(10) Eating disorders	No	59	3.25	1.823	0.072
	Yes	15	2.87		
(39) Uncertainty about treatments	No	58	2.93	0.760	0.796
	Yes	15	3.00		
(30) Sleep disorders	No	59	2.97	0.452	0.653
	Yes	15	2.87		
(19) Immediate health needs	No	59	2.47	1.264	0.240
	Yes	15	2.80		
(6) Coping with physical pains	No	58	2.57	0.412	0.681
	Yes	15	2.67		
(24) Night sitting when ill	No	58	1.81	1.141	0.258
	Yes	14	1.50		
All items	No	60	2.81	0.400	0.695
	Yes	15	2.71		

Group 5. Life-style arrangements

Table 36: The usefulness of counselling in dealing with clients' life-style arrangements: The perceptions of experienced counsellors and students (n = 75)

	Status	Number of respondents	Mean	t	p
(16) Housing	Experienced counsellor	30	1.83	0.172	0.864
	Student	45	1.80		
(21) Legal problems	Experienced counsellor	29	1.83	0.630	0.531
	Student	44	1.70		
(20) Income support and other financial benefits	Experienced counsellor	30	1.77	0.055	0.956
	Student	45	1.78		
(13) Furniture/household appliances	Experienced counsellor	30	1.47	1.019	0.312
	Student	44	1.64		
(17) Immigration/visas	Experienced counsellor	30	1.80	1.655	0.102
	Student	45	1.51		
(35) 24 hour-7 day a week home care	Experienced counsellor	29	1.55	0.586	0.559
	Student	44	1.45		
(25) Payment of bills	Experienced counsellor	29	1.48	0.101	0.920
	Student	45	1.47		
(34) Transport arrangements	Experienced counsellor	30	1.43	0.220	0.826
	Student	45	1.40		
All items	Experienced counsellor	30	1.65	0.565	0.581
	Student	45	1.60		

Table 37: The usefulness of counselling in dealing with clients' life-style arrangements: The perceptions of males and females (n = 74)

	Sex	Number of respondents	Mean	t	p
(16) Housing	Female	62	1.82	0.278	0.782
	Male	12	1.75		
(21) Legal problems	Female	60	1.80	1.163	0.249
	Male	12	1.50		
(20) Income support and other financial benefits	Female	62	1.81	0.828	0.411
	Male	12	1.58		
(13) Furniture/household appliances	Female	61	1.57	0.328	0.744
	Male	12	1.50		
(17) Immigration/visas	Female	62	1.61	0.225	0.823
	Male	12	1.67		
(35) 24 hour-7 day a week home care	Female	60	1.53	1.301	0.197
	Male	12	1.25		
(25) Payment of bills	Female	61	1.49	0.748	0.457
	Male	12	1.33		
(34) Transport arrangements	Female	62	1.45	1.423	0.159
	Male	12	1.17		
All items	Female	62	1.64	1.847	0.086
	Male	12	1.47		

Table 38: The usefulness of counselling in dealing with clients' life-style arrangements: The perceptions of respondents age ≤ 40 and > 40 years old (n = 75)

	Age	Number of respondents	Mean	t	p
(16) Housing	≤ 40 years old	21	2.00	1.238	0.220
	> 40 years old	54	1.74		
(21) Legal problems	≤ 40 years old	21	1.86	0.690	0.492
	> 40 years old	52	1.71		
(20) Income support and other financial benefits	≤ 40 years old	21	2.00	1.455	0.150
	> 40 years old	54	1.69		
(13) Furniture/household appliances	≤ 40 years old	20	1.75	1.365	0.177
	> 40 years old	54	1.50		
(17) Immigration/visas	≤ 40 years old	21	1.71	0.629	0.531
	> 40 years old	54	1.59		
(35) 24 hour-7 day a week home care	≤ 40 years old	21	1.71	1.766	0.082
	> 40 years old	52	1.40		
(25) Payment of bills	≤ 40 years old	21	1.57	0.798	0.428
	> 40 years old	53	1.43		
(34) Transport arrangements	≤ 40 years old	21	1.57	1.344	0.183
	> 40 years old	54	1.35		
All items	≤ 40 years old	21	1.77	2.430	**0.016**
	> 40 years old	54	1.55		

Table 39: The usefulness of counselling in dealing with clients' life-style arrangements: The perception between counselling experience under and over 6 years (n = 75)

	Length of counselling experience in years	Number of respondents	Mean	t	p
(16) Housing	None to over 5 years	39	1.77	0.484	0.630
	6 to over 20 years	36	1.86		
(21) Legal problems	None to over 5 years	39	1.67	1.976	0.332
	6 to over 20 years	34	1.85		
(20) Income support and other financial benefits	None to over 5 years	39	1.74	0.314	0.754
	6 to over 20 years	36	1.81		
(13) Furniture/household appliances	None to over 5 years	38	1.63	0.862	0.425
	6 to over 20 years	36	1.50		
(17) Immigration/visas	None to over 5 years	39	1.49	1.699	0.094
	6 to over 20 years	36	1.78		
(35) 24 hour-7 day a week home care	None to over 5 years	38	1.55	0.766	0.446
	6 to over 20 years	35	1.43		
(25) Payment of bills	None to over 5 years	39	1.44	0.502	0.617
	6 to over 20 years	35	1.51		
(34) Transport arrangements	None to over 5 years	39	1.44	0.317	0.753
	6 to over 20 years	36	1.39		
All items	None to over 5 years	39	1.59	0.589	0.565
	6 to over 20 years	36	1.64		

Table 40: The usefulness of counselling in dealing with clients' life-style arrangements: The perceptions of respondents with or without experience with clients with HIV/AIDS (n = 75)

	Working with clients with HIV/AIDS	Number of respondents	Mean	t	p
(16) Housing	No	60	1.82	0.070	0.944
	Yes	15	1.80		
(21) Legal problems	No	59	1.78	0.564	0.575
	Yes	14	1.64		
(20) Income support and other financial benefits	No	60	1.80	0.542	0.589
	Yes	15	1.67		
(13) Furniture/household appliances	No	59	1.59	0.619	0.538
	Yes	15	1.47		
(17) Immigration/visas	No	60	1.63	0.153	0.879
	Yes	15	1.60		
(35) 24 hour-7 day a week home care	No	58	1.52	0.584	0.561
	Yes	15	1.40		
(25) Payment of bills	No	60	1.50	0.720	0.474
	Yes	14	1.36		
(34) Transport arrangements	No	60	1.43	0.540	0.591
	Yes	15	1.33		
All items	No	60	1.63	1.253	0.231
	Yes	15	1.53		

Group 6. Social relationship issues

Table 41: The usefulness of counselling in dealing with clients' social relationship issues: The perceptions of experienced counsellors and students (n = 72)

	Status	Number of respondents	Mean	t	p
(27) Relationship problems	Experienced counsellor	30	3.60	1.910	0.060
	Student	45	3.80		
(8) Difficulty in social relationships	Experienced counsellor	29	3.45	0.496	0.622
	Student	45	3.51		
(36) Uncertainty about others' reactions	Experienced counsellor	28	3.36	0.825	0.412
	Student	44	3.48		
(18) Informing family or sexual partner of HIV status	Experienced counsellor	29	3.48	1.114	0.269
	Student	45	3.29		
(14) Having a normal life	Experienced counsellor	29	3.03	0.556	0.580
	Student	45	3.13		
All items	Experienced counsellor	30	3.38	0.391	0.706
	Student	45	3.44		

Table 42: The usefulness of counselling in dealing with clients' social relationship issues: The perceptions of males and females (n = 74)

	Sex	Number of respondents	Mean	t	p
(27) Relationship problems	Female	62	3.76	1.832	0.071
	Male	12	3.50		
(8) Difficulty in social relationships	Female	61	3.54	1.763	0.082
	Male	12	3.25		
(36) Uncertainty about others' reactions	Female	59	3.46	0.648	0.519
	Male	12	3.33		
(18) Informing family or sexual partner of HIV status	Female	61	3.38	0.546	0.587
	Male	12	3.25		
(14) Having a normal life	Female	61	3.10	0.292	0.771
	Male	12	3.17		
All items	Female	62	3.45	1.220	0.257
	Male	12	3.30		

Table 43: The usefulness of counselling in dealing with clients' social relationship issues: The perceptions of respondents age ≤ 40 and > 40 years old (n = 75)

	Age	Number of respondents	Mean	t	p
(27) Relationship problems	≤ 40 years old	21	3.62	1.210	0.230
	> 40 years old	54	3.76		
(8) Difficulty in social relationships	≤ 40 years old	21	3.43	0.589	0.557
	> 40 years old	53	3.51		
(36) Uncertainty about others' reactions	≤ 40 years old	20	3.25	1.598	0.115
	> 40 years old	52	3.50		
(18) Informing family or sexual partner of HIV status	≤ 40 years old	21	3.27	0.583	0.562
	> 40 years old	53	3.40		
(14) Having a normal life	≤ 40 years old	21	2.95	1.036	0.303
	> 40 years old	53	3.15		
All items	≤ 40 years old	21	3.51	0.272	0.792
	> 40 years old	54	3.46		

Table 44: The usefulness of counselling in dealing with clients' social relationship issues: The perception between counselling experience under and over 6 years (n = 75)

	Length of counselling experience in years	Number of respondents	Mean	t	p
(27) Relationship problems	None to over 5 years	39	3.79	1.504	0.136
	6 to over 20 years	36	3.64		
(8) Difficulty in social relationships	None to over 5 years	39	3.51	0.449	0.655
	6 to over 20 years	35	3.46		
(36) Uncertainty about others' reactions	None to over 5 years	38	3.50	1.037	0.303
	6 to over 20 years	34	3.35		
(18) Informing family or sexual partner of HIV status	None to over 5 years	39	3.36	0.073	0.942
	6 to over 20 years	35	3.37		
(14) Having a normal life	None to over 5 years	39	3.15	0.721	0.473
	6 to over 20 years	35	3.03		
All items	None to over 5 years	39	3.46	0.638	0.541
	6 to over 20 years	36	3.37		

Table 45: The usefulness of counselling in dealing with clients' social relationship issues: The perceptions of respondents having or having not had working experience with clients with HIV/AIDS (n = 75)

	Working with clients with HIV/AIDS	Number of respondents	Mean	t	p
(27) Relationship problems	No	60	3.78	2.512	**0.014**
	Yes	15	3.47		
(8) Difficulty in social relationships	No	60	3.50	0.452	0.653
	Yes	14	3.43		
(36) Uncertainty about others' reactions	No	58	3.47	1.005	0.319
	Yes	14	3.29		
(18) Informing family or sexual partner of HIV status	No	59	3.36	0.207	0.837
	Yes	15	3.40		
(14) Having a normal life	No	60	3.13	1.927	0.357
	Yes	14	2.93		
All items	No	60	3.45	1.000	0.347
	Yes	15	3.30		

Question B2

Table 46: The role of counsellors in the context of HIV/AIDS: The perceptions of experienced counsellors and students (n = 74)

Counsellors would perceive their own role as:		Counsellor/ supervisor	Student	Total	Chi-square	p
educator	No	22	35	57	0.073	0.786
	Yes	8	11	19		
	Total	30	46	76		
information-giver	No	19	27	46	0.163	0.686
	Yes	11	19	30		
	Total	30	46	76		
objective observer	No	21	27	48	1.997	0.318
	Yes	9	19	28		
	Total	30	46	76		
The funding agency would perceive the counsellor's role as:						
advisor	No	12	19	31	0.013	0.910
	Yes	18	27	45		
	Total	30	46	76		
educator	No	15	22	37	0.034	0.853
	Yes	15	24	39		
	Total	30	46	76		
facilitator	No	13	21	34	0.039	0.842
	Yes	17	25	42		
	Total	30	46	76		
information-giver	No	15	12	27	4.533	**0.033**
	Yes	15	34	49		
	Total	30	46	76		
objective observer	No	26	34	60	1.777	0.183
	Yes	4	12	16		
	Total	30	46	76		
Clients would perceive the counsellors' role as:						
advisor	No	11	12	23	0.963	0.326
	Yes	19	34	53		
	Total	30	46	76		
educator	No	20	34	54	0.464	0.496
	Yes	10	12	22		
	Total	30	46	76		
facilitator	No	14	19	33	0.213	0.645
	Yes	16	27	43		
	Total	30	46	76		
information-giver	No	12	19	31	0.013	0.910
	Yes	18	27	45		
	Total	30	46	76		
objective observer	No	22	34	56	0.003	0.955
	Yes	8	12	20		
	Total	30	46	76		

Table 47: The role of counsellors in the context of HIV/AIDS: The perceptions of females and males (n = 72)

The funding agency would perceive the counsellor's role as:		Female	Male	Total	Chi-square	p
educator	No	32	4	36	1.231	0.267
	Yes	31	8	39		
	Total	63	12	75		
facilitator	No	25	8	33	2.979	0.084
	Yes	38	4	42		
	Total	63	12	75		
Clients would perceive the counsellors' role as: facilitator	No	25	7	32	1.433	0.231
	Yes	38	5	43		
	Total	63	12	75		

Note: Only more than 80% of the cells contained at least 5 cases were calaulated.

Table 48: The role of counsellors in the context of HIV/AIDS: The perceptions of respondents age ≤ 40 and > 40 years old (n = 76)

Counsellors would perceive their own role as:		≤ 40 years old	> 40 years old	Total	Chi-square	p
educator	No	18	39	57	1.777	0.183
	Yes	3	16	19		
	Total	21	55	76		
information-giver	No	12	34	46	0.139	0.709
	Yes	9	21	30		
	Total	21	55	76		
objective observer	No	11	37	48	1.448	0.229
	Yes	10	18	28		
	Total	12	55	76		
The funding agency would perceive the counsellor's role as:						
advisor	No	11	20	31	1.614	0.204
	Yes	10	35	45		
	Total	21	55	76		
educator	No	8	29	37	1.302	0.254
	Yes	13	26	39		
	Total	21	55	76		
facilitator	No	10	24	34	0.098	0.755
	Yes	11	31	42		
	Total	21	55	76		
information-giver	No	8	19	27	0.084	0.772
	Yes	13	36	49		
	Total	21	55	76		
Clients would perceive the counsellors' role as:						
advisor	No	5	18	23	0.573	0.449
	Yes	16	37	53		
	Total	21	55	76		
educator	No	15	39	54	0.002	0.964
	Yes	6	16	22		
	Total	21	55	76		
facilitator	No	10	23	33	0.208	0.648
	Yes	11	32	43		
	Total	21	55	76		
information-giver	No	10	21	31	0.560	0.454
	Yes	11	34	45		
	Total	21	55	76		

Note: Only more than 80% of the cells contained at least 5 cases were calaulated.

Table 49: The role of counsellors in the context of HIV/AIDS: The perceptions of respondents having counselling experience ≤ 5 and over 6 years(n = 76)

Counsellors would perceive their own role as:		None to over 5 years	6 to over 20 years	Total	Chi-square	p
educator	No	34	23	57	6.338	0.012
	Yes	5	14	19		
	Total	39	37	76		
information-giver	No	25	21	46	0.429	0.513
	Yes	14	16	30		
	Total	39	37	76		
objective observer	No	22	26	48	1.568	0.211
	Yes	17	11	28		
	Total	39	37	76		
The funding agency would perceive the counsellor's role as:						
advisor	No	18	13	31	0.954	0.329
	Yes	21	24	45		
	Total	39	37	76		
educator	No	19	18	37	0.000	0.995
	Yes	20	19	39		
	Total	39	37	76		
facilitator	No	17	17	34	0.043	0.836
	Yes	22	20	42		
	Total	39	37	76		
information-giver	No	12	15	27	0.791	0.374
	Yes	27	22	49		
	Total	39	37	76		
objective observer	No	29	31	60	1.015	0.314
	Yes	10	6	16		
	Total	39	37	76		
Clients would perceive the counsellors' role as:						
advisor	No	10	13	23	0.811	0.368
	Yes	29	24	53		
	Total	30	37	76		
educator	No	31	23	54	2.771	0.096
	Yes	8	14	22		
	Total	39	37	76		
facilitator	No	17	16	33	0.001	0.976
	Yes	22	21	43		
	Total	39	37	76		
information-giver	No	19	12	31	2.085	0.149
	Yes	20	25	45		
	Total	39	37	76		
objective observer	No	27	29	56	0.819	0.365
	Yes	12	8	20		
	Total	39	37	76		

Note: Only more than 80% of the cells contained at least 5 cases were calaulated.

Table 50: The role of counsellors in the context of HIV/AIDS: The perceptions of respondents having or having not had working experience with clients with HIV/AIDS (n = 76)

Counsellors would perceive their own role as:		Having no experience	Having experience	Total	Chi-square	p
information-giver	No	38	8	46	0.405	0.575
	Yes	23	7	30		
	Total	61	15	76		
objective observer	No	41	7	48	2.184	0.139
	Yes	20	8	28		
	Total	61	15	76		
The funding agency would perceive the counsellor's role as:						
advisor	No	26	5	31	0.430	0.512
	Yes	35	10	45		
	Total	61	15	76		
educator	No	28	9	37	0.958	0.328
	Yes	33	6	39		
	Total	61	15	76		
facilitator	No	27	7	34	0.028	0.867
	Yes	34	8	42		
	Total	61	15	76		
information-giver	No	22	5	27	0.039	0.843
	Yes	39	10	49		
	Total	61	15	76		
Clients would perceive the counsellors' role as:						
facilitator	No	24	9	33	2.091	0.148
	Yes	37	6	43		
	Total	61	15	76		
information-giver	No	24	7	31	0.267	0.605
	Yes	37	8	45		
	Total	61	15	76		

Note: Only more than 80% of the cells contained at least 5 cases were calaulated.

Question B3 (a) to (c)

Table 51: The agreements on the risk of unprotected sexual activity of clients: The perceptions of counsellors & supervisors and students (n = 76)

	Status	n	Mean	t	p
Counsellors would accept the client's right to do so.	Experienced counsellor	29	2.24	1.148	0.255
	Student	45	2.02		
Counsellors should permit the client to make choices according to the client's own values.	Experienced counsellor	30	2.67	1.191	0.238
	Student	45	2.44		
Counsellor should not overlook the client's responsibility in preventing further infections to others and further deaths.	Experienced counsellor	30	3.23	1.482	0.143
	Student	45	3.47		
Counsellor should use all possible means to persuade clients not to place other lives at risk.	Experienced counsellor	30	2.90	1.059	0.294
	Student	46	3.13		
Counsellor should use all possible means to protect the third party.	Experienced counsellor	30	2.47	0.883	0.380
	Student	45	2.67		
All items	Experienced counsellor	30	2.70	0.143	0.890
	Student	46	2.75		

Table 52: The agreements on the risk of unprotected sexual activity of clients: The perceptions of females and males (n = 75)

	Sex	number of respondents	Mean	t	p
Counsellors would accept the client's right to do so.	Female	62	2.15	0.891	0.376
	Male	11	1.91		
Counsellors should permit the client to make choices according to the client's own values.	Female	62	2.56	0.918	0.362
	Male	12	2.33		
Counsellor should not overlook the client's responsibility in preventing further infections to others and further deaths.	Female	62	3.39	0.250	0.803
	Male	12	3.33		
Counsellor should use all possible means to persuade clients not to place other lives at risk.	Female	63	3.08	1.127	0.263
	Male	12	2.75		
Counsellor should use all possible means to protect the third party.	Female	62	2.66	1.361	0.178
	Male	12	2.25		
All items	Female	63	2.77	0.782	0.457
	Male	12	1.51		

Table 53: The agreements on the risk of unprotected sexual activity of clients: The perceptions of respondents age ≤ 40 and > 40 years old (n = 76)

	Age	number of respondents	Mean	t	p
Counsellors would accept the client's right to do so.	≤ 40 years old	20	2.10	0.052	0.958
	> 40 years old	54	2.11		
Counsellors should permit the client to make choices according to the client's own values.	≤ 40 years old	20	2.45	0.545	0.587
	> 40 years old	55	2.56		
Counsellor should not overlook the client's responsibility in preventing further infections to others and further deaths.	≤ 40 years old	20	3.35	0.180	0.858
	> 40 years old	55	3.38		
Counsellor should use all possible means to persuade clients not to place other lives at risk.	≤ 40 years old	21	3.00	0.227	0.821
	> 40 years old	55	3.05		
Counsellor should use all possible means to protect the third party.	≤ 40 years old	20	2.65	0.342	0.733
	> 40 years old	55	2.56		
All items	≤ 40 years old	21	2.71	0.071	0.945
	> 40 years old	55	2.73		

Table 54: The agreements on the risk of unprotected sexual activity of clients: The perceptions of respondents having counselling experience ≤ 5 and ≥ 6 years (n = 76)

	Counselling experience	number of respondents	Mean	t	p
Counsellors would accept the client's right to do so.	≤ 5 years	38	2.08	0.319	0.751
	≥ 6 years	36	2.14		
Counsellors should permit the client to make choices according to the client's own values.	≤ 5 years	38	2.50	0.366	0.715
	≥ 6 years	37	2.57		
Counsellor should not overlook the client's responsibility in preventing further infections to others and further deaths.	≤ 5 years	38	3.42	0.619	0.538
	≥ 6 years	37	3.32		
Counsellor should use all possible means to persuade clients not to place other lives at risk.	≤ 5 years	39	3.00	0.378	0.707
	≥ 6 years	37	3.08		
Counsellor should use all possible means to protect the third party.	≤ 5 years	38	2.61	0.169	0.866
	≥ 6 years	37	2.57		
All items	≤ 5 years	39	2.72	0.045	0.965
	≥ 6 years	37	2.74		

Table 55: The agreements on the risk of unprotected sexual activity of clients: The perceptions of respondents having or having not had working experience with clients with HIV/AIDS (n = 76)

	Working experience with clients with HIV/AIDS	n	Mean	t	p
Counsellors would accept the client's right to do so.	No	59	2.08	0.493	0.623
	Yes	15	2.20		
Counsellors should permit the client to make choices according to the client's own values.	No	60	2.47	1.465	0.147
	Yes	15	2.80		
Counsellor should not overlook the client's responsibility in preventing further infections to others and further deaths.	No	60	3.40	0.684	0.496
	Yes	15	3.27		
Counsellor should use all possible means to persuade clients not to place other lives at risk.	No	61	3.07	0.491	0.625
	Yes	15	2.93		
Counsellor should use all possible means to protect the third party.	No	60	2.67	1.454	0.150
	Yes	15	2.27		
All items	No	61	2.74	0.143	0.889
	Yes	15	2.69		

Table 56: The agreements on the risk of HIV transmission through blood: The perceptions of counsellors & supervisors and students (n = 75)

	Status	n	Mean	t	p
Counsellors would accept the client's right to do so.	Experienced counsellor	29	1.93	0.255	0.800
	Student	44	1.98		
Counsellors should permit the client to make choices according to the client's own values.	Experienced counsellor	29	2.45	0.894	0.375
	Student	44	2.27		
Counsellor should not overlook the client's responsibility in preventing further infections to others and further deaths.	Experienced counsellor	29	3.24	1.271	0.208
	Student	45	3.44		
Counsellor should use all possible means to persuade clients not to place other lives at risk.	Experienced counsellor	29	3.03	1.112	0.270
	Student	45	3.24		
Counsellor should use all possible means to protect the third party.	Experienced counsellor	29	2.59	2.264	**0.027**
	Student	46	3.04		
All items	Experienced counsellor	29	2.65	0.400	0.700
	Student	46	2.79		

Table 57: The agreements on the risk of HIV transmission through blood: The perceptions of females and males (n = 74)

	Sex	number of respondents	Mean	t	p
Counsellors would accept the client's right to do so.	Female	60	1.97	0.207	0.837
	Male	12	1.92		
Counsellors should permit the client to make choices according to the client's own values.	Female	60	2.33	0.317	0.752
	Male	12	2.42		
Counsellor should not overlook the client's responsibility in preventing further infections to others and further deaths.	Female	61	3.38	0.203	0.840
	Male	12	3.33		
Counsellor should use all possible means to persuade clients not to place other lives at risk.	Female	61	3.23	1.585	0.117
	Male	12	2.83		
Counsellor should use all possible means to protect the third party.	Female	62	2.92	1.213	0.229
	Male	12	2.58		
All items	Female	60	2.77	0.423	0.684
	Male	12	2.62		

Table 58: The agreements on the risk of HIV transmission through blood: The perceptions of respondents age ≤ 40 and > 40 years old (n = 74)

	Age	number of respondents	Mean	t	p
Counsellors would accept the client's right to do so.	≤ 40 years old	20	2.00	0.284	0.777
	> 40 years old	53	1.94		
Counsellors should permit the client to make choices according to the client's own values.	≤ 40 years old	20	2.30	0.270	0.788
	> 40 years old	53	2.36		
Counsellor should not overlook the client's responsibility in preventing further infections to others and further deaths.	≤ 40 years old	20	3.30	0.501	0.618
	> 40 years old	54	3.39		
Counsellor should use all possible means to persuade clients not to place other lives at risk.	≤ 40 years old	20	3.00	1.070	0.288
	> 40 years old	54	3.22		
Counsellor should use all possible means to protect the third party.	≤ 40 years old	20	2.90	0.234	0.816
	> 40 years old	54	2.85		
All items	≤ 40 years old	20	2.70	0.145	0.889
	> 40 years old	54	2.75		

Table 59: The agreements on the risk of HIV transmission through blood: The perceptions of respondents having counselling experience under and ≥ 6 years (n = 75)

	Counselling experience	number of respondents	Mean	t	p
Counsellors would accept the client's right to do so.	≤ 5 years	37	2.05	1.095	0.277
	≥ 6 years	36	1.86		
Counsellors should permit the client to make choices according to the client's own values.	≤ 5 years	37	2.35	0.093	0.926
	≥ 6 years	36	2.33		
Counsellor should not overlook the client's responsibility in preventing further infections to others and further deaths.	≤ 5 years	38	3.39	0.390	0.698
	≥ 6 years	36	3.33		
Counsellor should use all possible means to persuade clients not to place other lives at risk.	≤ 5 years	38	3.08	0.925	0.358
	≥ 6 years	36	3.25		
Counsellor should use all possible means to protect the third party.	≤ 5 years	39	2.92	0.578	0.565
	≥ 6 years	36	2.81		
All items	≤ 5 years	39	2.76	0.113	0.913
	≥ 6 years	36	2.72		

Table 60: The agreements on the risk of HIV transmission through blood: The perceptions of respondents having or having not had working experience with clients with HIV/AIDS (n = 75)

	Working experience with clients with HIV/AIDS	n	Mean	t	p
Counsellors would accept the client's right to do so.	No	59	1.98	0.559	0.578
	Yes	14	1.86		
Counsellors should permit the client to make choices according to the client's own values.	No	59	2.32	0.434	0.665
	Yes	14	2.43		
Counsellor should not overlook the client's responsibility in preventing further infections to others and further deaths.	No	60	3.40	0.928	0.357
	Yes	14	3.21		
Counsellor should use all possible means to persuade clients not to place other lives at risk.	No	60	3.22	1.226	0.224
	Yes	14	2.93		
Counsellor should use all possible means to protect the third party.	No	61	2.98	2.500	**0.015**
	Yes	14	2.36		
All items	No	61	2.78	0.619	0.553
	Yes	14	2.56		

Table 61: The agreements on the possibility of vertical transmission: The perceptions of counsellors & supervisors and students (n = 74)

	Status	n	Mean	t	p
Counsellors would accept the client's right to do so.	Experienced counsellor	29	2.48	0.030	0.976
	Student	44	2.48		
Counsellors should permit the client to make choices according to the client's own values.	Experienced counsellor	29	2.66	0.313	0.755
	Student	45	2.60		
Counsellor should not overlook the client's responsibility in preventing further infections to others and further deaths.	Experienced counsellor	29	3.07	1.272	0.207
	Student	45	3.27		
Counsellor should use all possible means to persuade clients not to place other lives at risk.	Experienced counsellor	29	2.76	1.849	0.069
	Student	44	3.11		
Counsellor should use all possible means to protect the third party.	Experienced counsellor	29	2.48	1.978	0.052
	Student	44	2.89		
All items	Experienced counsellor	29	2.69	0.975	0.358
	Student	45	2.87		

Table 62: The agreements on the possibility of vertical transmission: The perceptions of females and males (n = 73)

	Sex	number of respondents	Mean	t	p
Counsellors would accept the client's right to do so.	Female	60	2.53	1.198	0.235
	Male	12	2.25		
Counsellors should permit the client to make choices according to the client's own values.	Female	61	2.64	0.595	0.554
	Male	12	2.50		
Counsellor should not overlook the client's responsibility in preventing further infections to others and further deaths.	Female	61	3.20	0.143	0.886
	Male	12	3.17		
Counsellor should use all possible means to persuade clients not to place other lives at risk.	Female	60	3.02	1.029	0.308
	Male	12	2.75		
Counsellor should use all possible means to protect the third party.	Female	60	2.78	1.331	0.187
	Male	12	2.42		
All items	Female	61	2.83	1.072	0.315
	Male	12	2.62		

Table 63: The agreements on the possibility of vertical transmission: The perceptions of respondents age ≤ 40 and > 40 years old (n = 73)

	Age	number of respondents	Mean	t	p
Counsellors would accept the client's right to do so.	≤ 40 years old	20	2.45	0.205	0.838
	> 40 years old	53	2.49		
Counsellors should permit the client to make choices according to the client's own values.	≤ 40 years old	21	2.62	0.091	0.985
	> 40 years old	53	2.62		
Counsellor should not overlook the client's responsibility in preventing further infections to others and further deaths.	≤ 40 years old	20	3.10	0.710	0.480
	> 40 years old	54	3.22		
Counsellor should use all possible means to persuade clients not to place other lives at risk.	≤ 40 years old	20	2.90	0.464	0.644
	> 40 years old	53	3.00		
Counsellor should use all possible means to protect the third party.	≤ 40 years old	20	2.75	0.144	0.886
	> 40 years old	53	2.72		
All items	≤ 40 years old	20	2.76	0.265	0.798
	> 40 years old	53	2.81		

Table 64: The agreements on the possibility of vertical transmission: The perceptions of respondents having counselling experience under and ≥ 6 years (n = 74)

	Counselling experience	number of respondents	Mean	t	p
Counsellors would accept the client's right to do so.	≤ 5 years	37	2.57	1.022	0.310
	≥ 6 years	36	2.39		
Counsellors should permit the client to make choices according to the client's own values.	≤ 5 years	38	2.67	1.071	0.288
	≥ 6 years	36	2.53		
Counsellor should not overlook the client's responsibility in preventing further infections to others and further deaths.	≤ 5 years	38	3.18	0.067	0.947
	≥ 6 years	36	3.19		
Counsellor should use all possible means to persuade clients not to place other lives at risk.	≤ 5 years	37	2.97	0.004	0.997
	≥ 6 years	36	2.97		
Counsellor should use all possible means to protect the third party.	≤ 5 years	37	2.81	1.842	0.402
	≥ 6 years	36	2.64		
All items	≤ 5 years	38	2.84	0.594	0.569
	≥ 6 years	36	2.73		

Table 65: The agreements on the possibility of vertical transmission: The perceptions of respondents having or having not had working experience with clients with HIV/AIDS (n = 74)

	Working experience with clients with HIV/AIDS	n	Mean	t	p
Counsellors would accept the client's right to do so.	No	60	2.50	0.502	0.617
	Yes	13	2.38		
Counsellors should permit the client to make choices according to the client's own values.	No	60	2.65	0.685	0.495
	Yes	14	2.50		
Counsellor should not overlook the client's responsibility in preventing further infections to others and further deaths.	No	60	3.25	1.673	0.099
	Yes	14	2.93		
Counsellor should use all possible means to persuade clients not to place other lives at risk.	No	59	3.07	2.094	**0.040**
	Yes	14	2.57		
Counsellor should use all possible means to protect the third party.	No	60	2.82	1.949	0.055
	Yes	13	2.31		
All items	No	60	2.86	1.841	0.103
	Yes	14	2.54		

Question B4

1. Counselling methodology

Table 66: Aims of counselling - counselling methodology:
The perceptions of experienced counsellors and students (n = 76)

	Status	n	Mean	t	p
(5) listening carefully to clients' responses and helping them to talk through what HIV/AIDS means to them	Experienced counsellor	30	3.83	1.408	0.163
	Student	46	2.93		
(31) showing empathy	Experienced counsellor	30	3.63	2.782	**0.007**
	Student	46	3.93		
(20) being non-judgmental	Experienced counsellor	30	3.77	1.329	0.188
	Student	46	3.89		
(17) being accepting	Experienced counsellor	30	3.80	0.736	0.464
	Student	46	3.87		
(9) being understanding	Experienced counsellor	30	3.73	2.135	**0.036**
	Student	46	3.91		
(8) being sensitive to client's needs	Experienced counsellor	30	3.77	0.885	0.379
	Student	46	3.85		
(24) being supportive	Experienced counsellor	30	3.60	1.166	0.247
	Student	46	3.76		
(3) being caring	Experienced counsellor	30	3.53	1.785	0.078
	Student	46	3.76		
(2) being approachable	Experienced counsellor	30	3.53	1.165	0.248
	Student	46	3.67		
(6) being non-directive	Experienced counsellor	29	3.28	0.709	0.481
	Student	44	3.16		
(26) being friendly	Experienced counsellor	30	2.70	1.885	0.063
	Student	45	3.09		
All items	Experienced counsellor	30	3.65	0.573	0.573
	Student	46	3.71		

Table 67: Aims of counselling - counselling methodology: The perceptions of males and females (n = 75)

	Sex	n	Mean	t	p
(5) listening carefully to clients' responses and helping them to talk through what HIV/AIDS means to them	Female	63	3.92	1.768	0.081
	Male	12	3.75		
(31) showing empathy	Female	63	3.87	2.531	**0.014**
	Male	12	3.50		
(20) being non-judgmental	Female	63	3.87	1.640	0.105
	Male	12	3.67		
(17) being accepting	Female	63	3.87	1.640	0.105
	Male	12	3.67		
(9) being understanding	Female	63	3.90	3.018	**0.003**
	Male	12	3.58		
(8) being sensitive to client's needs	Female	63	3.87	2.497	**0.015**
	Male	12	3.58		
(24) being supportive	Female	63	3.79	3.627	**0.001**
	Male	12	3.17		
(3) being caring	Female	63	3.72	1.730	0.088
	Male	12	3.42		
(2) being approachable	Female	63	3.68	2.213	**0.030**
	Male	12	3.33		
(6) being non-directive	Female	60	3.28	1.740	0.086
	Male	12	2.92		
(26) being friendly	Female	62	2.94	0.066	0.947
	Male	12	2.92		
All items	Female	63	3.70	2.215	**0.039**
	Male	12	3.41		

Table 68: Aims of counselling - counselling methodology:
The perceptions of respondents age ≤ 40 and > 40 years old (n = 76)

	Age	n	Mean	t	p
(5) listening carefully to clients' responses and helping them to talk through what HIV/AIDS means to them	≤ 40 years old	21	3.86	0.653	0.516
	> 40 years old	55	3.91		
(31) showing empathy	≤ 40 years old	21	3.76	0.600	0.551
	> 40 years old	55	3.84		
(20) being non-judgmental	≤ 40 years old	21	3.90	0.838	0.404
	> 40 years old	55	3.82		
(17) being accepting	≤ 40 years old	21	3.76	1.077	0.285
	> 40 years old	55	3.87		
(9) being understanding	≤ 40 years old	21	3.81	0.476	0.636
	> 40 years old	55	3.85		
(8) being sensitive to client's needs	≤ 40 years old	21	3.67	2.105	**0.039**
	> 40 years old	55	3.87		
(24) being supportive	≤ 40 years old	21	3.67	0.279	0.781
	> 40 years old	55	3.71		
(3) being caring	≤ 40 years old	21	3.67	0.043	0.966
	> 40 years old	55	3.67		
(2) being approachable	≤ 40 years old	21	3.57	0.489	0.627
	> 40 years old	55	3.64		
(6) being non-directive	≤ 40 years old	12	2.86	2.893	**0.005**
	> 40 years old	52	3.35		
(26) being friendly	≤ 40 years old	21	3.14	1.276	0.206
	> 40 years old	54	2.85		
All items	≤ 40 years old	21	3.61	0.476	0.640
	> 40 years old	55	3.67		

Table 69: Aims of counselling - counselling methodology: The perception between counselling experience under and over 6 years (n = 76)

	counselling experience	n	Mean	t	p
(5) listening carefully to clients' responses and helping them to talk through what HIV/AIDS means to them	None to over 5 years	39	3.90	0.078	0.938
	6 to over 20 years	37	3.89		
(31) showing empathy	None to over 5 years	39	3.87	1.041	0.301
	6 to over 20 years	37	3.76		
(20) being non-judgmental	None to over 5 years	39	3.92	1.832	0.071
	6 to over 20 years	37	3.76		
(17) being accepting	None to over 5 years	39	3.85	0.090	0.929
	6 to over 20 years	37	3.84		
(9) being understanding	None to over 5 years	39	3.87	0.722	0.473
	6 to over 20 years	37	3.81		
(8) being sensitive to client's needs	None to over 5 years	39	3.79	0.477	0.635
	6 to over 20 years	37	3.84		
(24) being supportive	None to over 5 years	39	3.72	0.311	0.757
	6 to over 20 years	37	3.68		
(3) being caring	None to over 5 years	39	3.69	0.343	0.732
	6 to over 20 years	37	3.65		
(2) being approachable	None to over 5 years	39	3.64	0.390	0.698
	6 to over 20 years	37	3.59		
(6) being non-directive	None to over 5 years	38	3.16	0.615	0.541
	6 to over 20 years	35	3.26		
(26) being friendly	None to over 5 years	38	2.97	0.395	0.694
	6 to over 20 years	37	2.89		
All items	None to over 5 years	39	3.67	0.283	0.780
	6 to over 20 years	37	3.63		

Table 70: Aims of counselling - counselling methodology: The perceptions of respondents having or having not had working experience with clients with HIV/AIDS (n = 76)

	working with clients with HIV/AIDS	n	Mean	t	p
(5) listening carefully to clients' responses and helping them to talk through what HIV/AIDS means to them	No	61	3.89	0.538	0.593
	Yes	15	3.93		
(31) showing empathy	No	61	3.89	2.632	**0.010**
	Yes	15	3.53		
(20) being non-judgmental	No	61	3.89	1.921	0.059
	Yes	15	3.67		
(17) being accepting	No	61	3.84	0.263	0.794
	Yes	15	3.87		
(9) being understanding	No	61	3.85	0.493	0.623
	Yes	15	3.80		
(8) being sensitive to client's needs	No	61	3.80	0.561	0.576
	Yes	15	3.87		
(24) being supportive	No	61	3.74	1.207	0.231
	Yes	15	3.53		
(3) being caring	No	61	3.67	0.034	0.973
	Yes	15	3.67		
(2) being approachable	No	61	3.62	0.153	0.878
	Yes	15	3.60		
(6) being non-directive	No	60	3.25	1.194	0.236
	Yes	13	3.00		
(26) being friendly	No	60	2.95	0.322	0.748
	Yes	15	2.87		
All items	No	61	3.67	0.687	0.500
	Yes	15	3.58		

2. Information and prevention

Table 71: Aims of counselling - information and prevention:
The perceptions of experienced counsellors and students (n = 75)

	Status	n	Mean	t	p
(16) helping clients to adopt safer sex practice	Experienced counsellor	27	3.11	0.637	0.526
	Student	44	3.23		
(12) having good networks with other professionals	Experienced counsellor	30	3.27	2.347	**0.022**
	Student	46	3.59		
(23) helping clients to reduce other risk factors	Experienced counsellor	28	3.14	0.035	0.972
	Student	44	3.14		
(18) providing facts about HIV/AIDS	Experienced counsellor	29	2.72	2.007	**0.049**
	Student	44	3.09		
(7) providing information about infection control issues	Experienced counsellor	29	2.79	1.317	0.192
	Student	44	3.02		
(32) providing facts about transmission	Experienced counsellor	29	2.69	0.990	0.326
	Student	43	2.88		
(1) making sure that clients know how to reach the counsellor in case of difficulty	Experienced counsellor	29	2.90	1.370	0.175
	Student	45	3.11		
(25) preventing the spread of HIV infection and AIDS	Experienced counsellor	27	2.37	1.447	0.152
	Student	45	2.71		
All items	Experienced counsellor	29	2.87	1.611	0.129
	Student	46	3.01		

Table 72: Aims of counselling - information and prevention:
The perceptions of males and females (n = 75)

	Sex	n	Mean	t	p
(16) helping clients to adopt safer sex practice	Female	59	3.24	1.746	0.085
	Male	11	2.82		
(12) having good networks with other professionals	Female	63	3.54	2.498	**0.015**
	Male	12	3.08		
(23) helping clients to reduce other risk factors	Female	60	3.18	1.988	0.141
	Male	11	2.82		
(18) providing facts about HIV/AIDS	Female	60	3.00	1.350	0.181
	Male	12	2.67		
(7) providing information about infection control issues	Female	60	3.02	2.279	**0.026**
	Male	12	2.50		
(32) providing facts about transmission	Female	59	2.90	2.233	**0.029**
	Male	12	2.33		
(1) making sure that clients know how to reach the counsellor in case of difficulty	Female	62	3.03	0.571	0.570
	Male	11	2.91		
(25) preventing the spread of HIV infection and AIDS	Female	60	2.60	0.450	0.654
	Male	11	2.45		
All items	Female	63	3.06	2.772	**0.015**
	Male	12	2.70		

Table 73: Aims of counselling - information and prevention:
The perceptions of respondents age ≤ 40 and > 40 years old (n = 76)

	Age	n	Mean	t	p
(16) helping clients to adopt safer sex practice	≤ 40 years old	20	3.20	0.119	0.905
	> 40 years old	51	3.18		
(12) having good networks with other professionals	≤ 40 years old	21	3.52	0.567	0.573
	> 40 years old	55	3.44		
(23) helping clients to reduce other risk factors	≤ 40 years old	20	3.10	0.269	0.789
	> 40 years old	52	3.15		
(18) providing facts about HIV/AIDS	≤ 40 years old	21	3.05	0.711	0.480
	> 40 years old	52	2.90		
(7) providing information about infection control issues	≤ 40 years old	21	3.05	0.859	0.393
	> 40 years old	52	2.88		
(32) providing facts about transmission	≤ 40 years old	21	2.90	0.659	0.512
	> 40 years old	51	2.76		
(1) making sure that clients know how to reach the counsellor in case of difficulty	≤ 40 years old	20	3.00	0.212	0.832
	> 40 years old	54	3.04		
(25) preventing the spread of HIV infection and AIDS	≤ 40 years old	20	2.75	0.898	0.372
	> 40 years old	52	2.52		
All items	≤ 40 years old	21	3.07	0.697	0.497
	> 40 years old	55	2.98		

Table 74: Aims of counselling - information and prevention:
The perception between counselling experience under and over 6 years (n = 76)

	counselling experience	n	Mean	t	p
(16) helping clients to adopt safer sex practice	None to over 5 years	38	3.13	0.624	0.534
	6 to over 20 years	33	3.24		
(12) having good networks with other professionals	None to over 5 years	39	3.56	1.563	0.122
	6 to over 20 years	37	3.35		
(23) helping clients to reduce other risk factors	None to over 5 years	38	3.03	1.343	0.184
	6 to over 20 years	34	3.26		
(18) providing facts about HIV/AIDS	None to over 5 years	38	2.95	0.025	0.981
	6 to over 20 years	35	2.94		
(7) providing information about infection control issues	None to over 5 years	39	2.92	0.105	0.917
	6 to over 20 years	34	2.94		
(32) providing facts about transmission	None to over 5 years	37	2.70	1.101	0.275
	6 to over 20 years	35	2.91		
(1) making sure that clients know how to reach the counsellor in case of difficulty	None to over 5 years	38	3.05	0.340	0.735
	6 to over 20 years	36	3.00		
(25) preventing the spread of HIV infection and AIDS	None to over 5 years	37	2.57	0.140	0.889
	6 to over 20 years	35	2.60		
All items	None to over 5 years	39	2.99	0.304	0.766
	6 to over 20 years	37	3.03		

Table 75: Aims of counselling - information and prevention:
The perceptions of respondents having or having not had working experience with clients with HIV/AIDS (n = 76)

	working experience with clients with HIV/AIDS	n	Mean	t	p
(16) helping clients to adopt safer sex practice	No	59	3.14	1.199	0.235
	Yes	12	3.42		
(12) having good networks with other professionals	No	61	3.46	0.044	0.965
	Yes	15	3.47		
(23) helping clients to reduce other risk factors	No	60	3.12	0.555	0.581
	Yes	12	3.25		
(18) providing facts about HIV/AIDS	No	59	2.97	0.467	0.642
	Yes	14	2.86		
(7) providing information about infection control issues	No	59	2.97	0.826	0.411
	Yes	14	2.79		
(32) providing facts about transmission	No	59	2.80	0.197	0.845
	Yes	13	2.85		
(1) making sure that clients know how to reach the counsellor in case of difficulty	No	60	3.08	1.530	0.130
	Yes	14	2.79		
(25) preventing the spread of HIV infection and AIDS	No	60	2.58	0.000	1.000
	Yes	12	2.58		
All items	No	61	3.02	0.093	0.928
	Yes	15	3.00		

3. Decision making and change

Table 76: Aims of counselling - decision making and change:
The perceptions of experienced counsellors and students (n = 76)

	Status	n	Mean	t	p
(22) improving clients' self-concept and self-esteem	Experienced counsellor	29	3.66	0.725	0.471
	Student	46	3.74		
(15) helping clients to decide who else they wished to tell about their HIV status	Experienced counsellor	30	3.43	0.851	0.397
	Student	44	3.55		
(14) helping clients to deal with relationship issues	Experienced counsellor	30	3.33	1.905	0.061
	Student	45	3.58		
(29) reducing anxiety and depression	Experienced counsellor	29	3.31	1.614	0.111
	Student	45	3.56		
(30) helping clients to inform sexual partners	Experienced counsellor	29	3.07	1.187	0.239
	Student	44	3.27		
(13) helping clients to arrange a social support network or to make the best use of them	Experienced counsellor	29	2.97	1.364	0.177
	Student	44	3.20		
(10) encouraging clients to prepare for death	Experienced counsellor	29	2.76	0.637	0.526
	Student	45	2.87		
(27) promoting behaviour and attitude change	Experienced counsellor	28	2.57	0.351	0.727
	Student	44	2.64		
(4) being directive	Experienced counsellor	29	1.79	1.673	0.099
	Student	45	2.04		
All items	Experienced counsellor	30	2.99	0.659	0.519
	Student	46	3.16		

Table 77: Aims of counselling - decision making and change:
The perceptions of males and females (n = 74)

	Sex	n	Mean	t	p
(22) improving clients' self-concept and self-esteem	Female	62	3.81	4.712	**0.000**
	Male	12	3.17		
(15) helping clients to decide who else they wished to tell about their HIV status	Female	61	3.57	2.394	**0.019**
	Male	12	3.17		
(14) helping clients to deal with relationship issues	Female	62	3.56	2.883	**0.005**
	Male	12	3.08		
(29) reducing anxiety and depression	Female	61	3.54	2.770	**0.007**
	Male	12	3.00		
(30) helping clients to inform sexual partners	Female	60	3.27	2.345	**0.022**
	Male	12	2.75		
(13) helping clients to arrange a social support network or to make the best use of them	Female	60	3.17	1.431	0.157
	Male	12	2.83		
(10) encouraging clients to prepare for death	Female	61	2.89	1.733	0.088
	Male	12	2.50		
(27) promoting behaviour and attitude change	Female	59	2.64	0.938	0.352
	Male	12	2.42		
(4) being directive	Female	61	1.92	0.409	0.684
	Male	12	2.00		
All items	Female	62	3.15	1.617	0.126
	Male	12	2.77		

Table 78: Aims of counselling - decision making and change:
The perceptions of respondents age ≤ 40 and > 40 years old (n = 75)

	Age	n	Mean	t	p
(22) improving clients' self-concept and self-esteem	≤ 40 years old	21	3.62	0.971	0.335
	> 40 years old	54	3.74		
(15) helping clients to decide who else they wished to tell about their HIV status	≤ 40 years old	21	3.29	2.141	**0.036**
	> 40 years old	53	3.58		
(14) helping clients to deal with relationship issues	≤ 40 years old	21	3.24	2.435	**0.017**
	> 40 years old	54	3.57		
(29) reducing anxiety and depression	≤ 40 years old	21	3.33	1.060	0.293
	> 40 years old	53	3.51		
(30) helping clients to inform sexual partners	≤ 40 years old	21	3.05	1.089	0.280
	> 40 years old	52	3.25		
(13) helping clients to arrange a social support network or to make the best use of them	≤ 40 years old	21	3.14	0.243	0.808
	> 40 years old	52	3.10		
(10) encouraging clients to prepare for death	≤ 40 years old	21	2.81	0.112	0.911
	> 40 years old	53	2.83		
(27) promoting behaviour and attitude change	≤ 40 years old	20	2.55	0.420	0.676
	> 40 years old	52	2.63		
(4) being directive	≤ 40 years old	21	2.00	0.456	0.650
	> 40 years old	53	1.92		
All items	≤ 40 years old	21	3.00	0.482	0.636
	> 40 years old	54	3.13		

Table 79: Aims of counselling - decision making and change:
The perception between counselling experience under and over 6 years (n = 75)

	Length of counselling experience in years	n	Mean	t	p
(22) improving clients' self-concept and self-esteem	None to over 5 years	39	3.72	0.207	0.836
	6 to over 20 years	36	3.69		
(15) helping clients to decide who else they wished to tell about their HIV status	None to over 5 years	38	3.47	0.417	0.678
	6 to over 20 years	36	3.53		
(14) helping clients to deal with relationship issues	None to over 5 years	39	3.54	0.950	0.345
	6 to over 20 years	36	3.42		
(29) reducing anxiety and depression	None to over 5 years	39	3.51	0.749	0.456
	6 to over 20 years	35	3.40		
(30) helping clients to inform sexual partners	None to over 5 years	38	3.26	1.881	0.381
	6 to over 20 years	35	3.11		
(13) helping clients to arrange a social support network or to make the best use of them	None to over 5 years	38	3.08	0.368	0.714
	6 to over 20 years	35	3.14		
(10) encouraging clients to prepare for death	None to over 5 years	39	2.79	0.703	0.484
	6 to over 20 years	35	2.89		
(27) promoting behaviour and attitude change	None to over 5 years	38	2.63	0.240	0.811
	6 to over 20 years	34	2.59		
(4) being directive	None to over 5 years	39	1.97	0.402	0.689
	6 to over 20 years	35	1.91		
All items	None to over 5 years	39	3.11	0.114	0.910
	6 to over 20 years	36	3.08		

Table 80: Aims of counselling - decision making and change: The perceptions of respondents having or having not had working experience with clients with HIV/AIDS (n = 76)

	working experience with clients with HIV/AIDS	n	Mean	t	p
(22) improving clients' self-concept and self-esteem	No	61	3.74	1.155	0.252
	Yes	14	3.57		
(15) helping clients to decide who else they wished to tell about their HIV status	No	60	3.47	1.070	0.288
	Yes	14	3.64		
(14) helping clients to deal with relationship issues	No	60	3.50	0.623	0.535
	Yes	15	3.40		
(29) reducing anxiety and depression	No	60	3.48	0.656	0.514
	Yes	14	3.36		
(30) helping clients to inform sexual partners	No	60	3.23	1.060	0.293
	Yes	13	3.00		
(13) helping clients to arrange a social support network or to make the best use of them	No	60	3.08	0.651	0.517
	Yes	13	3.23		
(10) encouraging clients to prepare for death	No	60	2.83	0.225	0.823
	Yes	14	2.79		
(27) promoting behaviour and attitude change	No	59	2.66	1.189	0.238
	Yes	13	2.38		
(4) being directive	No	60	1.92	0.814	0.418
	Yes	14	2.07		
All items	No	61	3.10	0.201	0.843
	Yes	15	3.05		

4. Health care and domestic concerns

Table 81: Aims of counselling- health care and domestic concerns:
The perceptions of experienced counsellors and students (n = 74)

	Status	n	Mean	t	p
(11) encouraging clients to take positive steps to maintain and improve general health	Experienced counsellor	29	3.03	1.547	0.126
	Student	45	3.31		
(21) informing clients about what hospital and voluntary services are available and how to access them	Experienced counsellor	29	2.66	2.520	**0.014**
	Student	44	3.07		
(28) making sure that clients have adequate medical support and services	Experienced counsellor	29	2.66	0.189	0.850
	Student	45	2.09		
(19) helping client with practical problems such as housing, welfare benefits, etc.	Experienced counsellor	28	1.68	3.262	**0.002**
	Student	45	2.20		
All items	Experienced counsellor	29	2.51	0.822	0.443
	Student	45	2.82		

Table 82: Aims of counselling- health care and domestic concerns:
The perceptions of males and females (n = 73)

	Sex	n	Mean	t	p
(11) encouraging clients to take positive steps to maintain and improve general health	Female	61	3.30	2.331	**0.023**
	Male	12	2.75		
(21) informing clients about what hospital and voluntary services are available and how to access them	Female	60	2.95	1.669	0.099
	Male	12	2.58		
(28) making sure that clients have adequate medical support and services	Female	61	2.74	1.740	0.086
	Male	12	2.33		
(19) helping client with practical problems such as housing, welfare benefits, etc.	Female	61	2.02	0.860	0.392
	Male	12	1.82		
All items	Female	61	2.75	1.133	0.301
	Male	12	2.37		

Table 83: Aims of counselling- health care and domestic concerns:
The perceptions of respondents age ≤ 40 and > 40 years old (n = 74)

	Age	n	Mean	t	p
(11) encouraging clients to take positive steps to maintain and improve general health	≤ 40 years old	21	3.10	0.765	0.447
	> 40 years old	53	3.25		
(21) informing clients about what hospital and voluntary services are available and how to access them	≤ 40 years old	12	3.00	0.731	0.467
	> 40 years old	52	2.87		
(28) making sure that clients have adequate medical support and services	≤ 40 years old	21	2.62	0.411	0.682
	> 40 years old	53	2.70		
(19) helping client with practical problems such as housing, welfare benefits, etc.	≤ 40 years old	20	2.30	1.292	0.025
	> 40 years old	53	1.89		
All items	≤ 40 years old	21	2.76	0.228	0.827
	> 40 years old	53	2.68		

Table 84: Aims of counselling- health care and domestic concerns:
The perception between counselling experience under and over 6 years (n = 74)

	counselling experience	n	Mean	t	p
(11) encouraging clients to take positive steps to maintain and improve general health	None to over 5 years	39	3.18	0.276	0.783
	6 to over 20 years	35	3.23		
(21) informing clients about what hospital and voluntary services are available and how to access them	None to over 5 years	38	2.95	0.539	0.591
	6 to over 20 years	35	2.86		
(28) making sure that clients have adequate medical support and services	None to over 5 years	39	2.56	1.373	0.174
	6 to over 20 years	35	2.80		
(19) helping client with practical problems such as housing, welfare benefits, etc.	None to over 5 years	39	2.13	1.680	0.097
	6 to over 20 years	34	1.85		
All items	None to over 5 years	39	2.71	0.054	0.959
	6 to over 20 years	35	2.69		

Table 85: Aims of counselling - health care and domestic concerns: The perceptions of espondents having or having not had working experience with clients with HIV/AIDS (n = 74)

	working experience with clients with HIV/AIDS	n	Mean	t	p
(11) encouraging clients to take positive steps to maintain and improve general health	No	60	3.18	0.452	0.652
	Yes	14	3.29		
(21) informing clients about what hospital and voluntary services are available and how to access them	No	60	2.93	0.753	0.454
	Yes	13	2.77		
(28) making sure that clients have adequate medical support and services	No	60	2.65	0.613	0.542
	Yes	14	2.79		
(19) helping client with practical problems such as housing, welfare benefits, etc.	No	60	2.07	1.755	0.084
	Yes	13	1.69		
All items	No	60	2.71	0.176	0.866
	Yes	14	2.64